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INDIAN HEALTH ISSUES ANCHORAGE, ALASKA

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

INDIAN HEALTH ISSUES

JUNE 3, 1983

ANCHORAGE, ALASKA

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INDIAN HEALTH ISSUES
ANCHORAGE, ALASKA

JUNE 3, 1983

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Anchorage, Alaska.

The committee met, pursuant to notice, at 9 a.m., in room C-117, The Federal Building, Anchorage, Alaska, Senator Frank Murkowski (acting chairman) presiding.

Present: Senator Murkowski.

Staff present: Patricia Zell, staff attorney and Allen Korhonen, administrative assistant to Senator Murkowski.

Senator MURKOWSKI. Good morning. I would like to welcome you to the formal opening of the hearing we are scheduled to have today, under the auspices of the Select Committee on Indian Affairs.

I very much appreciate the fine turnout that we have this morning, and I think it is indicative of the significance of this hearing. Hopefully, the record that will be made as a consequence of the testimony will be meaningful in changing procedures, applications, and administration to result in better services to the people of Alaska who utilize the services of Indian Health.

Before I get into my formal opening statement, I would like to introduce to you those seated at the head table. I think it is extremely important that we have with us this morning Dr. Rhoades. Dr. Rhoades comes to Alaska as the Director of Indian Health Service. He has been to Alaska previously but not in the position of director.

I have on my immediate left from the professional staff in Washington, the staff attorney for health issues from the Select Committee on Indian Affairs, Pat Zell. Pat has been very instrumental in developing the outstanding witness list and the procedure and has done an awful lot of research. We are very happy to have her with us.

I have Allen Korhonen of my staff. Allen is on the Select Committee as well, representing my office. He is no stranger to Alaska, having been in Juneau for the last several years as deputy commissioner of the Department of Health and Social Services. Allen has spent a lot of time traveling in many of the bush areas of Alaska. While the role of the State is no stranger to Allen, in his new position as a member of my staff, he is responsible not only for health affairs but Native affairs as well.

We also have a young lady who is going to make this record. That is Marianne Lindley, who is a court reporter.

Dr. Rhoades, would you like to make a brief opening statement before I make a more lengthy one?

STATEMENT OF DR. EVERETT RHOADES, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. RHOADES. Thank you very much. I will make some very brief comments. I do have a prepared statement that I will submit for the record, Senator Murkowski——

Senator MURKOWSKI. You may read it into the record or summarize it, whichever you wish.

Dr. RHOADES. Let me just make two or three points that are contained in that.

Senator MURKOWSKI. Surely.

Dr. RHOADES. First of all, I want to thank you on behalf of Indian Health Service for your continued interest in the health of Native Americans and for taking time out of your schedule to travel here to get the perspective of the local consumers as well as providers. That is a perspective that as a Director of Indian Health Service I am well aware is a special one and not always adequately reflected in the testimony that we in headquarters prepare.

I am sure that I do not need to recapitulate what will, I think, develop during the course of this hearing; that is, that the delivery of health services to Alaskan Natives is substantially different from that of, I suppose, any other people in the world, but specifically different from all the other responsibilities that Indian Health Service has to those deemed eligible for its services. The extraordinary distances, the remote nature of a number of its residences and the disease processes themselves are quite different.

I just came here from making rounds in the medical center here, and was presented with an Alaskan Native patient with botulism. My previous medical specialty is infectious diseases, and this is only about the third patient with botulism that I have encountered. Of course, that is a special situation in the Native population here.

Indian Health Service is caught in the vortex of a number of currents that are going on at the present time in the delivery of health services that in some ways reflects the changes that are going on in this country, but in my years of experience with my own tribe, before becoming Director of Indian Health Service, and especially in the last number of months after becoming the Director of Indian Health Service, those adverse effects that come to bear on all the population in this country are magnified and made substantially more acute in Indian populations, so that in many respects Indian health care, Indian people and Indian Health Service represents a microcosm of the forces that are going on in this country at the present time.

For example, a serious question being debated is indeed whether the United States has sufficient resources to provide all of the medical care for its citizens that is now technologically available, and this is a serious question for Indian Health Service and Indian people.

In addition, we are embarked upon a continuing process of transferring our activities over to the Indian people themselves. This began in its earliest phases, as a matter of fact, in the Alaska area, gradually increased, received a great stimulus under the legislation of the Indian Self-Determination and Education Assistance Act, Public Law

93–638, and in the process of transferring over an extremely complicated delivery system with many facets, there are a number of administrative difficulties that I am well aware give the Native people a great deal of difficulty, just as it does us.

I am aware that the communications between any facility and another facility, and especially between Indian Health Service and Indian communities, could be strengthened enormously, and I am seeking ways to do that.

We in Indian Health Service take the responsibility very, very seriously, the responsibility for insuring the best possible health that can be provided under the circumstances and the responsibility of increasing the transfer of the operation of these facilities over to the Native people. In this regard, I believe that the deliberations by the Select Committee on Indian Affairs, of which you here are participating, will be very important in providing us guidance and counsel as we continue through this period, and I just want to thank you for the opportunity of letting me participate also.

[The prepared statement follows:]

PREPARED STATEMENT OF DR. EVERETT R. RHOADES, DIRECTOR, INDIAN HEALTH SERVICE, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee: I am Dr. Everett R. Rhoades, Director of the Indian Health Service (IHS). With me is Mr. Gerald Ivey of the Anchorage Area Office. I am pleased to be here today in Alaska. Mr. Ivey will be glad to discuss with you and your Committee any questions about the operation of the health care programs by IHS in the local area and I will be glad to discuss with you any overall policy questions.

As you know, the IHS represents the primary Federal health commitment to approximately 900,000 eligible American Indians and Alaska Natives living on or near Federal Indian reservations and in traditional Indian Country. The IHS carries out this mission through a comprehensive health delivery system providing high quality preventive, curative, rehabilitative, and environmental health services. It does this through programs managed and operated by both the IHS and various tribes utilizing both direct and contract health services. In addition, limited health services are provided in 37 urban locations having an Indian population of about 300,000—half of whom are included in the 900,000 figure.

The total IHS service population for the Alaska Area Office is approximately 68,692.

To date the fiscal year 1983 appropriation to the IHS for health services totals $658,183,000.00. The IHS Area's apportionment of the fiscal year 1983 appropriation includes $98,880,900 for Alaska.

The IHS is constantly endeavoring to provide quality health care to Indian people while recognizing that the medical needs of Indian people demand a special measure of priority and attention from the Federal Government.

In 1976, in the Indian Health Care Improvement Act, the Congress defined the scope of the IHS program and established a national goal of providing the highest possible health status to Indian people while encouraging maximum Indian participation in health programs.

In your letter of invitation you stated that you wished to discuss the need to reauthorize the Indian Health Care Improvement Act, Public Law 94–437. As you know, section 701 requires the Secretary to submit to Congress a final report on Public Law 94–437 including an assessment and recommendations. That process has only recently been initiated so I cannot at this time report on any Departmental decisions.

Mr. Chairman, that concludes my opening remarks. At this time we will be happy to answer any questions you may have.

Senator MURKOWSKI. Thank you very much, Dr. Rhoades. I think that the fact that we have in you the individual that is responsible ultimately for the delivery of these services makes this hearing even more meaningful.

I would like to just summarize in my opening remarks to the witnesses that it is vitally important that we in Congress hear from you. You are the recipients most affected by this legislation and in the best position to help us examine, at the source, the problems that the legislation is intended to remedy.

I am personally happy that we are holding these hearings here in Alaska because that is where they belong. I believe the Select Committee on Indian Affairs will get more reliable information from the testimony and it will be shared with my colleagues in deliberating Native health matters.

The principal purpose of the hearing today is to hear testimony on the reauthorization of the Indian Health Care Improvement Act, Public Law 94-437. The act establishes a number of programs that benefit Alaska's Native residents. Our community health aide and community health representative programs are authorized under the rural health components of the act, as are the village sanitation projects.

In addition to a general discussion of the Indian Health Care Improvement Act, I would like to hear more about specific problems that are occurring in Alaska's Native villages. There may be other ways in which the program established by the act could help in solving some of the problems unique to Alaska. I welcome any information that you can provide to the committee in exploring ways to tailor the act to the special needs of Alaskans.

For example, the serious nature of the sanitation requirements in many of the remote villages is certainly increasingly clear to all of us. In some of the villages, sewage and sanitation facilities are inadequate or lacking altogether. In other villages, the facilities have been provided but are not properly maintained. Conditions like these contribute heavily to the deterioration of the health of the village residents. This is a matter of great concern to us.

One unfortunate consequence of the poor village sanitation facilities has been the rise and spread of the hepatitis B virus which is of growing concern. Hepatitis B is estimated to have infected as much as 8 percent of all the Yupik Eskimo population; in some communities as much as 25 percent of the population has been infected. This is clearly a medical emergency of the first magnitude, and the government agencies responsible for the eradication of this disease, very frankly, are not doing enough. In our opinion, it has been projected that the cost of controlling the hepatitis B epidemic could be as much as $5.5 million. To date, neither the State of Alaska nor the Federal Government has appeared willing to shoulder its fair share of this expense and obligation. I would hope today that we hear some solutions to what may well be a stalemate on this problem.

I have also had expressions of concern in my office with the Indian Health Service contracts authorized under the Public Law 93-638, and I am sure we are going to hear some testimony on that this morning. The obstacles to administering these contracts have been described to me, and include erratic and unpredictable schedules for disbursing funds for contractors, questionable staffing assumptions used by IHS in allocating funds for community health programs, and the effects of nationwide cuts on the public health budget. The latter invokes a certain amount of criticism that has been frequently leveled at the IHS administration, that the budget cuts are expected to be absorbed at the service level without proportional cuts at the administration level. Both the health service contractors and the Federal officials charged with administering these programs will testify today on these general matters.

Finally, I am interested in hearing your views on community health aide/community health representative programs, both of which are widely supported in rural Alaska. Community Health Aides [CHA] and Community Health Representatives [CHR] often provide the first, and in many instances the only, line of defense against injury and the spread of disease in the smaller community bush areas. We hope to learn more today about how these programs may be strengthened or improved.

Again, I want to thank you for your participation.

Dr. Rhoades, we appreciate the fact that you are here with us, and we look forward to you sharing the message that is going to be given here this morning.

In view of the number of witnesses that we have and the fact that we hope to conclude this hearing sometime shortly after noon, we are going to have to limit each witness to about 5 minutes. I have done a quick count and it appears that if we limit witnesses to 5 minutes, we are looking at almost 4 hours of hearing, and we do not have 4 hours between 9 and 12 o'clock. We are going to start with panel one.

I would call up Janie Leask, president of the Alaska Federation of Natives.

Caleb Pungowiji, Alaska Federation of Natives Board member. Caleb, it is a pleasure to have you with us this morning.

Nina Dahl, Alaska Federation of Natives board member.

William Williams, president of Tanana Chiefs Conference.

Kenneth Charlie, chairman, Alaska Native Health Board; and Agnes Nichols, vice chairman, Alaska Native Health Board.

I want to assure you, first of all, Dr. Rhoades, that your entire opening statement will be entered into the record as read, as will the other statements of the witnesses that are about to testify. We could appreciate any summarization that you would care to make by simply summarizing your written testimony to make your points. We are going to have to limit the individual testimony to 5 minutes.

Janie, please proceed.

STATEMENT OF JANIE LEASK, PRESIDENT, ALASKA FEDERATION OF NATIVES

Ms. **Leask.** Thank you, Mr. Chairman.

I appreciate the opportunity to testify this morning. I am testifying on behalf of the Alaska Federation of Natives [AFN], which is composed of the 13 regional corporations established under the Alaska Native Claims Settlement Act and 11 of the 12 nonprofit Native associations that are charged with the responsibility for providing human services to Native people throughout Alaska. AFN, through its membership, represents approximately 80,000 Alaska Natives.

I have submitted written testimony, and I will summarize those comments here.

Senator **Murkowski**. Thank you.

Ms. **Leask**. I also request that the hearing record be kept open long enough to allow Native individuals in other organizations who are not here today to be able to submit written testimony.

Senator **Murkowski**. The record will be held open for 30 days.

Ms. **Leask**. Thank you.

The Alaska Federation of Natives supports reauthorization of the Indian Health Care Improvement Act. Reauthorization of the act is significant because it will reflect a renewed commitment by Congress to fulfilling its special responsibility and legal obligation to Native American people. The act itself reflects a national policy of raising the level of Native health as high as possible and providing Native Health Services with all the resources necessary to attain that goal.

Although the act has never been fully funded, it represents an important statement by Congress that the Federal Government recognizes the need, though largely unmet, for Indian health services. We feel very strongly that this committee must hear and also take back to Congress the message that the health care needs of Alaska Natives are not being addressed as aggressively as Congress had intended. For the general health of Alaska Natives is getting worse, but not for the most part because of the communicable diseases which plagued us more than 20 years ago.

Two decades ago, the Federal Government reacted swiftly and effectively to combat such life-threatening diseases as tuberculosis and smallpox. Just this year we were heartened to see the State and Federal Governments' initial response to the hepatitis B problem, but the real threat now to the Native well-being stems from such modern diseases such as alcoholism, mental illness, cancer, heart disease, hypertension, stroke, and arthritis, just to name a few.

We hope that Congress will respond to this crisis as it did to the smallpox and tuberculosis, because we feel very strongly that we do face a crisis.

AFN emphatically recommends that prior commitments, commitments that were made in good faith to bring Native health standards up to the level of the general population, be met. Native health care must be raised to national standards, and our major health problems must be tackled immediately and aggressively.

A comprehensive health care system that works must include culturally relevant preventive programs with a maximum of local control.

While Alaska Natives have many major health and health care problems, there is one area which stands out as the most threatening to our health, our lives, and our culture. That problem is alcohol and drug abuse. It affects every aspect of rural community life and undermines the very survival of Alaska Native people.

Alcohol and drug abuse has become a vicious cycle, destroying Native families and communities, a cycle that must be broken.

In response to the committee's request for reaction to the IHS task force on contract health care services, AFN objects to the expanded scope of work undertaken by the task force. It is totally inappropriate for the task force to address the mission of the Indian Health Service.

In doing so, the task force made what we feel are inaccurate and misleading statements about the special relationship between the Federal Government and American Indians and Alaska Natives.

In closing, I would like to emphasize again that we enthusiastically support the intent and the purpose of the Indian Health Care Improvement Act, but the intent and the purpose must become a reality. As implemented thus far, the act has yet to raise Native health to the level envisioned by Congress, a level which every Alaska Native and American Indian has a right to expect and to attain. It is simply not acceptable to continue the cycle of substandard inadequate services and programs. Our health problems must be tackled aggressively and they must be tackled now.

Senator **MURKOWSKI.** Thank you, Janie.

Ms. **LEASK.** Thank you.

Senator **MURKOWSKI.** I very much appreciate that testimony. It is very meaningful and you have made your points very well.

[The prepared statement follows:]

PREPARED STATEMENT OF JANIE LEASK, PRESIDENT, ALASKA FEDERATION OF NATIVES, INC.

Mr. Chairman, members of the Senate Select Committee on Indian Affairs and honored guests: Welcome to Alaska. My name is Janie Leask. I am president of the Alaska Federation of Natives and I am testifying today on behalf of that organization.

The Alaska Federation of Natives is composed of the 13 regional corporations formed under the Alaska Native Claims Settlement Act, and 11 of the 12 nonprofit regional corporations charged with responsibility for providing human services to Native people throughout Alaska. More than 80,000 Alaska Natives are represented by our member organizations.

Alaska is divided into 12 regional areas based on boundaries determined by the Alaska Native Claims Settlement Act. Each region has a corporation, which administers the settlement, and a non-profit corporation charged with providing human services for the Natives in that region. In five of the 12 regions, there is also a regional health corporation which contracts with Indian Health Service. In the other 7 regions, the non-profit corporations contract with IHS for health services.

The Alaska Federation of Natives supports reauthorization of the Indian Health Care Improvement Act. Reauthorization of the act is significant because it will reflect a renewed commitment, by Congress, to fulfilling its special responsibility and legal obligation to Native American people. The act, itself, reflects a national policy of raising the status of Native health as high as possible, and providing Native health services with all the resources necessary to attain that goal.

Although the act has never been fully funded, it represents an important statement by Congress that the federal government recognizes the need—largely unmet—for Indian health services.

The Indian Health Care Improvement Act explicitly recognizes that the resources appropriated for Indian health services have been grossly inadequate to respond to the actual health needs of American Indians and Alaska Natives. Those needs were identified more than 10 years ago, yet they are still not being met.

This committee must hear and take back to Congress the message that the health care needs of Alaska Natives are not being addressed as aggressively as Congress intended when it passed the Act in 1976.

The health status of Alaska Natives is threatened by more "modern" curses; ones that threaten to do just as much damage as the diseases in earlier years. The health of Alaska Natives is deteriorating at a dramatic rate because of alcoholism, mental illness, cancer, heart disease, hypertension, stroke, and arthritis. We hope that Congress will respond to this crisis, just as it did before. Because, we do indeed face a crisis.

We—Alaska Native people—are faced with monumental problems that we cannot combat alone. The major problems we face include, but are not limited to, inadequate or non-existent prevention programs; inadequate programs addressing mental health and alcoholism; federal budget cuts which threaten Native health care with exponential impacts; reduced access to health care facilities caused by cuts in transportation funds; poor conditions in clinics and hospitals; and inadequate communications which hamper primary care delivery.

There is more * * * a comprehensive, effective health care system for Alaska Natives is handicapped by a lack of coordination between state and federal programs; inadequate contract care funding; inadequate commitment from government agencies to the development of regional health corporations (which provide many services through contracts to Alaska Natives); difficulties in recruiting and keeping skilled staff; inadequate dental care for children; and practically no dental care for Native adults.

We cannot afford to ignore that the Reagan administration's solution to the nation's economic woes is to reduce domestic spending. That policy has made Congress hesitant to initiate new programs requiring additional funding.

But, in spite of that hesitation, AFN emphatically recommends that prior commitments—made in good faith to bring Native health standards up to the level of the general population—be met. Native health care must be brought up to national standards and our major health problems must be tackled aggressively.

That will never happen, if the Indian Health Service policy continues to restrict resources only to life or limb-threatening situations, while neglecting or eliminating other primary care services and prevention programs.

As long as the IHS continues its narrow focus, the health problems of Alaska Natives will continue to receive only a band-aid approach. As long as prevention is given short shrift the long-term effects of federal programs will be negligible.

A comprehensive health care system that works must include culturally relevant preventive care programs, with a maximum of local control and adaptable to local Native needs. Existing preventative care programs must receive priority equal to primary health care.

While Alaska Natives have many major health and health care problems, there is one area which stands out clearly as the most threatening to our health, our lives and our culture. That problem is alcohol and drug abuse. It affects every aspect of rural community life and threatens the very survival of Alaska Native people and our traditional way of life.

Alcohol and drug abuse continues to be the most significant contributing factor in violent crimes, accidental death, suicide and domestic violence among Alaska Natives. Alcohol and drug abuse has become a vicious cycle, destroying Native families and communities. It must be broken.

Alcoholism and drug abuse is a complex problem with sociological, physical, emotional and possibly genetic roots. The complexity of the problem demands that Indian Health Service have the flexibility to deal with it. We suggest a study of the National Congress of American Indians [NCAI] proposal to create an office of Alcoholism and Drug Abuse Programs. The existing IHS program, with its focus on a medical model, is too restrictive to adequately or effectively deal with the problem. The conventional, western approach simply has not worked and will not work for Alaska Natives.

Some aspects of the rural health care system are working, yet they are threatened with elimination because of federal cutbacks in the Reagan administration's proposed budget. One such effective program is the community health representative.

The Community Health Representative Program, a vital link in rural health care, was implemented in 1968 to improve the health knowledge, attitudes and practices of Native people. It has been successful in Alaska, due in part to the broad community support the program has received at the local level.

Alaska Natives have ways of life different from those of non-natives. An effective health care system must integrate standard health care practices with a thorough understanding of Native cultures, to ensure that differences are used constructively to reap the highest possible level of health and health care.

Community Health Representatives are effective because they are members of the Native community, reside in the same rural area and are selected by the community. Their unique position enables them to work effectively on prevention, health awareness, nutrition, physical health and traditional health care. We strongly urge Congress to continue this program with adequate funding.

The Community Health Aide Program is another example of an effective locally-based, community-supported program. While the Community Health Representative focuses generally on prevention and available resources, the Community Health Aide is a surrogate doctor or nurse, providing primary care in the absence of a trained professional.

Community Health Aides are of critical value for several reasons. They provide immediate, accessible primary medical care. Up to 80 percent of the primary care provided to rural Natives comes through the Community Health Aide. The Community Health Aide helps the Native community to become more self-reliant and self-sufficient for primary care within the community. The Community Health Aide Program is culturally relevant—and it works. There is strong local support because the aide is a member of the community, is selected for training by that community and is responsive to the community's immediate need.

The Community Health Aide Program must have continued funding at an adequate level because it is the core of the whole rural health delivery system. Training of aides should continue with increased access to "State of the Art" medical information. The Aide position should be upgraded in both wages and career potential. The Community Health Aides also need better access to equipment and supplies locally. Clinics and other local facilities must be brought up to standards, including minimum square footage, heating, and have adequate water and sewer systems that work.

In response to the committee's request for reaction to the IHS Task Force, AFN objects to the expanded scope of work undertaken by the IHS Contract Health Services Task Force. It is totally inappropriate for the task force to address the mission of IHS, which was assigned responsibility for carrying out the federal commitment to provide comprehensive, high quality health care to American Indians and Alaska Natives, free of individual liability for payment. In its report, the task force made inaccurate and misleading statements about the special relationship between the federal government and American Indians and Alaska Natives.

AFN supports efforts to table the IHS Contract Health Services report until tribes can thoroughly review the report's recommendations and until those recommendations are approved by the affected tribes.

On a more pleasant note, AFN supports elevation of the Director of Indian Health Services position to the level of Assistant Secretary. Elevating the position would reduce certain management problems encountered with various levels of the Department of Health and Human Services.

In closing, I would like to emphasize again that we enthusiastically support the intent and the purpose of the Indian Health Care Improvement Act. But the intent and the purpose must become reality. As implemented so far, the Act has yet to raise Native health to the level envisioned by Congress; a level which every Alaska Native and American Indian has a right to expect and attain.

It is simply not acceptable to continue the cycle of substandard inadequate services and programs.

Our health problems must be tackled aggressively; and they must be tackled now.

In the long run, we will ALL benefit.

Thank you.

Senator MURKOWSKI. The next witness is Caleb Pungowiji.

STATEMENT OF CALEB PUNGOWIJI, REPRESENTING THE NORTON SOUND HEALTH CORP.

Mr. PUNGOWIJI. I want to thank you for the opportunity to testify before this panel. My testimony today is on behalf of Norton Sound Health Corp., one of the regional health corporations within the State of Alaska. I am also on the board of the human resources of Alaska Federation of Natives.

On behalf of Norton Sound Health Corp. and the people of the Bering Straits region whom I represent, we commend the efforts taken by Congress and the President to maintain and improve the health status of Alaska Natives required by the Federal Government's historical and unique relationship to Native Americans.

In the last decade, we have seen improvements in our regional health facility. We have made the first steps in realizing our goals toward Native manpower development with the firm belief that this will begin to stabilize staffing of health care providers. We have instituted high standards incorporating the guidance of a consumer-directed board composed of representatives from all our villages and the community of Nome. Our contractual relationship with Indian Health Service has enabled us to create a unique community health services system. This system, developed by us, includes primary community health aides who are recruited in each village and who are trained and supervised regionally. Moreover, we have a community-based hospital which serves the entire population of about 8,000 people; of these, approximately 80 percent are Alaska Natives.

Despite the gains we have directed, and despite those which have been afforded us by efforts at the State and national level, we still have unmet health needs which must be addressed before we will reach parity with the health status of other American citizens. Our primary concern is that new Members of Congress and others who make decisions which affect the delivery of health services to Alaska Natives do not delude themselves into believing that these past efforts have cured the problems.

Most of our villages haul ice for drinking water and use small pots, known as honey buckets, for human waste disposal. The health and safety of these villages is endangered daily by inadequate sanitation. While some sanitation systems do exist, they were often poorly constructed for this environment and there has been little consideration for operation and maintenance.

I might also add that several years ago there was a three-party agreement between Indian Health Service, BIA, and HUD in the construction of new housing, that there would be water and sewer programs connected with these new housing programs.

The houses have been built, but to date there has been no improvement in the water and sewer programs for the villages.

Without being too graphic in our description of water and waste disposal in rural Alaska, please try to imagine what life is like when every dish washed, every tooth brushed and every diaper laundered must be accomplished with hand-carried water, and even the health clinics have honey buckets which are used by ill patients. With nonexistent waste disposal, it is no wonder that we have an exponential rate of transmitted diseases that have been all but eradicated in the rest of America, such as hepatitis A, salmonella, and shigella.

Another significant health status indicator is infant mortality, which is still quite high among our people. Despite routine well-baby checkups and good prenatal and neonatal care by parents, meningitis deaths among infants still occur annually within our region. Those children who do recover are often impaired or disabled and require ongoing special medical treatment for the rest of their life. While the infant mortality rate for white Alaskans has dropped from over 21 to less than 10 per 1,000 live births over the last decade, the rate for Alaskan

Natives has only dropped from about 28 to about 21 per 1,000 live births.

The other disease which is not often considered a problem in the rest of America is tuberculosis. This is still being actively treated in rural Alaska. Not only are we treating active cases, but we are regularly dealing with medical complications from the past epidemics.

In addition to these direct patient care needs, preventive care has been sadly neglected; increasingly so with the recent budget cuts and with no hope in the near future to address these needs.

Examples of the greatest needs are accident prevention and medical problems associated with social concerns such as alcoholism, mental illness, dental caries, and eye and ear disorders. Furthermore, our people still suffer from poor access, limited communications and transportation systems, and severe climate, all of which make the provision of health care a difficult task, at best.

The high utilization of health services by the people demonstrate an increased confidence in the providers. It also shows a positive outcome of the health promotion activities we were able to conduct in recent years before the drastic funding cuts. It is very important to us that the Federal Government not, at this time, attempt to convince itself that the health status of Alaskan Natives is at parity with the rest of the American population. Our people now trust that the providers are skilled; they now seek help early, and do not delay until a condition is chronic. To stop in midstream the advances made so far would most certainly leave our people to be quickly swept back to their previous status before they realize the full health afforded their fellow citizens.

The 94th Congress took the right step in the right direction when they enacted the Indian Health Care Improvement Act. We endorse reauthorization of the Public Law 94-437 and pursuant appropriations at a level which will allow full implementation of that act.

Thank you.

Senator MURKOWSKI. Thank you very much, Mr. Pungowiji.

[The prepared statements follow. Testimony resumes on p. 23.]

PREPARED STATEMENTS OF THE NORTON SOUND HEALTH CORPORATION

Topic: Community Health Aides & Community Health Representatives

The Community Health Aide program for Norton Sound Health Corporation is unique in its design and systems approach. Local villagers are recruited for training as Health Aides, and the training is conducted in Nome at the Health Corporation. The Health Aides in the Norton Sound villages are the first responders and are the sole primary care providers for all residents in the villages. They are on call 24 hours a day for emergencies, in addition to providing regular clinic hours Monday through Friday. The Health Aides maintain daily consultation by radio, when operational, with physicians at the Norton Sound Regional Hospital in Nome.

Patient encounters for the fifteen villages total over 28,000 per year. These villages are accessible only by air, with an average roundtrip airfare of $170 to reach the hospital, and $300 to $1,000 if a charter is necessary for emergency medical evacuation. The next available source of health care is provided in Anchorage, over 500 airmiles away, at an average roundtrip cost of $360 from Nome to Anchorage.

There are Health Aide programs elsewhere in the United States and the world that are using our model to develop their own village health care systems. The stability of such a system is self-evident. By training local residents to provide medical care there is no excessive staff turnover, the primary care providers know and have the trust of the patients, there is continuity of care for entire families rather than individual and/or isolated patient encounters, travel costs are held to a minimum, and lives are saved because of the emergency care that can be delivered immediately.

In addition to the Community Health Aides, Norton Sound Health Corporation has a unique Community Health Representative (CHR) program. This program was implemented to impart health knowledge and to improve the health care practices and attitudes of Native Americans as an adjunct to the primary care delivered by Indian Health Services. Nationally, CHR's are utilized as "outreach" workers to identify potential patients in need of primary care and to act as a liaison between patients and the medical professionals. Like the Health Aides, CHR's are recruited from among the target population to be served. They understand and represent the patients and also provide stability in a field fraught with high turnover.

Due to funding cuts in terms of inflation-adjusted budgets during recent years, Norton Sound Health Corporation has expanded the scope of CHR duties to include many primary care services. The particular programs where the CHR's provide these primary care services include eye care, dental hygiene, outpatient services, and community mental health.

Our eye care technician is CHR funded. We have mental health paraprofessionals who travel to the villages to provide follow-up and support counseling. Another primary care CHR of Norton Sound is the dental hygienist who assists the dentists in the central clinic and on village service trips. The hospital's outpatient clinic appointment clerk is a CHR, who makes appointments and performs patient intakes. Other CHR's who provide some primary care are the patient driver who transports patients unable to walk to the horpital for inpatient or outpatient services, the boarding home clerk, and the travel clerk.

Norton Sound Health Corporation has been fortunate in having some budget flexibility not afforded other IHS facilities. As a 638 contractor we have been able to initiate many cost-containment measures. Our ability to reorganize and consolidate services among the various departments of the corporation has enabled us to eliminate a great deal of administrative overhead. Likewise, we have agressively sought other health care related projects which can share these administrative costs, further reducing the IHS-funded portions of administration.

Nonetheless, the federal and state cuts in funding have reached a critical level in our region. For several years we have pared and reduced and streamlined activities, training, and functions within the Community Health Aide program. We cannot continue to neglect normal training and development of this program without a detrimental effect on the patients we serve. Likewise, with the proposed phase-out and defunding of the CHR program at a federal level, we would be greatly affected, in that our CHR's provide many primary care functions.

We urge that you consider organizations such as ours in your deliberations, and not judge the overall question of areas to fund solely on national averages or IHS facility methods of operation. It would be grossly unfair to the Native Americans we serve to deny them health care afforded others in the nation due to the semantics of funding categories which do not properly define our utilization or our need.

Testimony by the
Norton Sound Health Corporation
before the
U.S. Senate Indian Affairs Committee
Oversight Hearings on IHS P.S. 94-437
Topic: Response to "Contract Health Services Task Force Report"

Since the inception of P.L. 93-638 it seems to us as 638 contractors at times, that the federal administration, and in particular the Indian Health Services bureaucracy, is doing everything in its power to thwart the development of American Native tribal organizations to assume and operate health care services for their own people. Much of this reluctance to release control has been offered under the guise of "helping" the Native people or "cooperating" with Indian tribes.

While, during periods of frustration, we can rationalize by saying, "they are just trying to protect their jobs, "or the "bureaucracy is so big that we just have to put up with it...,you can't change the government," we as Native people cannot just continue to lie down only to be railroaded by a system that is beyond anyone's total comprehension or control. This is not to imply that all government employees with whom we deal are against our efforts toward self-determination. However, the ones that do sympathize with our cause are often left equally frustrated because of the stifling system under which they must work.

The shortcomings of this system have nothing to do with our naivete or lack of "downtown" sophistication. The voice of the Native people must be heard by the one democratic avenue we have—our legislative representatives.

One recent example of efforts made to hinder the intent of P.L. 93-638 Indian self-determination is that of the Director's Task Force on Contract Health Services printed in February 1983. In reviewing this report I am reminded of a story once related to me by one of our staff members. The story, as told, is as follows:

Fable of the Efficient Bus Company

There is a story of an excellent city bus department. It was famous for its clean busses, courteous and careful drivers, and happy employees. The passengers always knew when and where to catch a bus, because the company faithfully followed the bus stop schedule. Everyone appreciated such a fine transportation system.

One year as the price of gasoline increased, the company needed to build a new maintenance garage. The bus company looked for ways to maintain services and stick to the budget with the increasing costs. The employees needed raises, the main office equipment and furnishings were wearing out and needed replacing, and the city's administration was also implementing new reporting requirements that meant additional clerical help had to be hired. The bus company manager did time studies, hired consultants, and developed a four-drawer file cabinet full of research data. He hired a statistical analyst to evaluate the results.

Shortly thereafter it was noted in the local newspaper that passengers were beginning to complain. Nearly empty busses were racing past bus stops, by-passing lines of waiting passengers. The courteous bus drivers would wave, but did not stop. When the bus company manager was interviewed, he explained that with the new system in place, and with the increasing costs, some of the drivers and maintenance workers had been laid off. There were fewer busses on the city's streets. In order to stick to the schedule, it was necessary to make fewer stops.

By the end of a year the passenger revenues had decreased dramatically, because fewer people were riding the bus. The streets of the city were congested mornings and afternoons with commuters who had purchased automobiles to get to work. The city streets were often barricaded for repairs as the increased traffic took its toll on the deteriorating pavement, and the police were overworked and griping about the number of accident reports they were having to complete.

At the end of the second year the bus company rarely stopped to pick up passengers in an effort to keep to their schedule and maintain their system, but the manager took pride in the fact that once they had "gotten rid of the passengers, the system ran just fine!"

MORAL: As systems develop, it is easy to lose sight of people we serve.

Although labeled as an examination of contract health services, the task force report attempts to address other areas of "related health services" not immediately identified by the title of the document. Without careful scrutiny of its contents, one might not realize the implications of the widely scoped recommendations provided by the task force. In this case, the phrase "never judge a book by its cover" definitely applies. In its conclusion the report specifies that the task force reviewed the recommendations,

> "in light of the charge of the IHS Director that it identify potential improvements of the CHS and health services delivery program and make recommendations for program policy **without** affecting adversely the relationship of IHS to its service population." [boldface is ours]

Further, the task force states that,

> "implementation of its recommendations will make IHS a more viable, effective, and efficient provider of health services,"

and that,

> "Those improvements—which would be made in cooperations with the Indian tribes—would have a highly salutory effect on the health status of the service population."

It makes one wonder how the twelve men who made up this task force, ten of whom work within the IHS federal system, can make the above statements, without realizing that the 24 recommendations outlined potentially **have** the impact of adversely affecting the relationship between IHS to its service population. To point out a few basic problem areas, consider the following:

1. The imposition of a blood quantum requirement from Headquarters limits the flexibility of 638 contractors and Indian tribes to customize their approach to services eligibility for the populations they serve. Is a family which is comprised of members with differing levels of Indian blood to be split because one is considered to be less an Indian than another?

2. The implementation of service priorities according to categories is especially distressing. For example, Category A's Effective Preventive Measures have always remained a goal for 638 contractors. However, this service is difficult to evaluate, and it has continually fallen by the wayside when cuts were made, in favor of keeping intact the more basic direct services. Imposing wide-scale priorities on 638 contractors again takes the flexibility away from 638 contractors, therefore destroying the intent of true Indian self-determination.

3. Additionally, the steps outlined in Appendix "D" to determine treatment of medical priorities, while it may work in some areas of the United States, definitely has negative connotations for rural areas of Alaska where the entire regional population depends on small service hospitals as the only source of health care.

While our criticisms of this report can go on and on, suffice it to say for purposes of this testimony that we, as a 638 contractor, feel that the recommendations of this task force should not be taken lightly. We also feel that sufficient time needs to be taken to analyze the impact of implementing such recommendations.

Since the issues are technical and the potential consequences are far-reaching, the "bus passengers", or Native tribes, need more time than the unrealistic time frame recommended by the task force to respond to the report and to present some input. Otherwise, we will be left waiting at the "bus stop" while the IHS bureaucratic system keeps running.

Given the opportunity, we are certain that the "bus passengers" can provide a task force report to the IHS Director that would meet the criteria of improving the quality and cost benefits of provision of Indian health care by analyzing the administration and structure of the "bus line" system.

Testimony by the
Norton Sound Health Corporation
before the
U.S. Senate Indian Affairs Committee
Oversight Hearings on P.L. 94-437

Topic: Re-Authorization of the Act

On September 30, 1976, the United States Congress passed the Indian Health Care Improvement Act. This legislation was designed to provide the Indian Health Service (IHS) of the Department of Health and Human Services with the legislative authority and Congressional mandate to fill the gaps currently existing in the health delivery system serving Native American people. The Act identified a number of specific areas on which the IHS was to work and seven (7) years within which to completely address the needs identified by Public Law 94-437. While the intentions of the Act are excellent, it was drastically underfunded.

Title I. Indian Health Manpower is the only reliable source of future Indian health professionals. It is the best way to protect against Indian health manpower shortages in the years to come. Seven years is far too short a time to complete training in medical or nursing school, given that the ideal future health providers, American Indians, first had to be identified and the scholarships needed to be publicized. We are seeing the first results of reaching those goals toward Native manpower development. We firmly believe that if the Act is re-authorized and money appropriated this will begin to stabilize staffing of health care providers.

In addition to our support of the existing authorities established in §102—Health Professionals Recruitment, §103—Health Preparatory and Pre-Graduate Scholarships (for four [4] years as per 1980 amendments), §104—Health Professions Scholarships, §105—IHS Extern Program for §103 and §104 Students, and §106—Continuing Education Allowances, Norton Sound Health Corporation recommends the following amendments:

1. Expand §103's preparatory and pre-graduate program to include scholarships for pre-nursing, pre-medical technologist, pre-physical therapy students, and paraprofessional training leading to certification (such as for Community Health Aides).
2. Add a provision to §104 to limit the award of health professional scholarships to Native American students. Currently, Indian scholarship applicants only receive preference for such awards.

3. Expand the §105 extern program to include recipients of §103 scholarships.

4. In order to protect the funding for these scholarships, include language in the re-authorized law to require that all monies appropriated by Congress for Indian health manpower be expended for that sole purpose.

Title II. This part of the Act concerns health services prioritizations that needed to be addressed in the seven-year period. Funds appropriated, as written in the law, "shall be in addition to the level of appropriations" in this Act and other such federal laws. At the service level we have experienced operating budget funding only for program maintenance with some program cut-backs and eliminations. However, at area and headquarters levels within IHS there have been major expansions, resulting in an oversized bureaucratic system that is top-heavy, giving credence to the euphemism of "too many chiefs and not enough Indians."

Granted, in the last decade we have seen improvements in our regional health facility, but our village "health" clinics are still in need of essential improvements. "Honey buckets" (excrement chamber pots) are the current state of the art for sewage disposal in village health clinics. Moreover, 20% of our villages are without any form of potable water systems or solid waste sites, and systems in other villages are extremely primitive. Federal recreation campsites in the "lower 48" have better conveniences for public sanitation.

If you consider the rate of water borne diseases in our area, it is no wonder that this rate is significantly higher in our area than the rest of the United States. According to the 1982 State Health Plan for Alaska, the three-year average for 1978-80 Alaska's incidence of Shigella was 26.4 per 100,000 population, while the U.S. as a whole had a rate of .09 per 100,000 population. Our state had a Hepatitis "A" incidence rate of 18.1 compared to the national rate of 14 per 100,000 population. Incidentally, there is some suggestion that the incidence of Giardia Lamblia is increasing. Although it is not a reportable disease, there were over 60 cases reported in Alaska in 1980 and 1981.

Conclusion. Access to health services has improved with implementation of the Act. The Act authorizes eligibility of IHS facilities under the Medicare program and service provided to Medicaid-eligible Indians. The FY '84 IHS budget includes $67 million from third party sources. This shift in financing is a great concern of ours. We believe that it was the intent of the law to identify additional funds from Medicare, Medicaid, and other sources, not to use such funds to decrease general IHS funding levels.

We urge this Committee to re-authorize the Indian Health Care Improvement Act and to include language to restore the legislative intent of implementing a program that will:

1. insure that the health status of Indian people is at parity with that of the general U.S. population, and
2. achieve the maximum participation of Indian people in Indian health programs.

Testimony by the
Norton Sound Health Corporation
before the
U.S. Senate Indian Affairs Committee
Oversight Hearings on IHS P.L. 94-437

Topic: Water & Waste Disposal Systems

While almost every American citizen has taken running water and flush toilets for granted for decades, in the Norton Sound and Bering Straits Region almost every village resident is without these sanitation essentials. Acquiring drinkable water is a major part of a typical family's day, especially during harsh winter months. An example is when a villager nearly lost his life attempting to supply drinking water for his family. He was caught in a winter "white out" while traveling by snow machine to the nearest fresh water lake to chop blocks of ice to melt down. Local search and rescue teams did not locate him until the following day, and he suffered frostbite and hypothermia symptoms.

However, danger in procuring water is only one health hazard. Families rely on small pots called "honey buckets" as toilets. Some, but not all, communities have designated "dump" sites. Residents dump their pots and garbage outside the community, as far from the houses as human strength and weather conditions allow. When temperatures are far below zero, the distance is limited.

Hepatitis, scabies, impetigo, salmonella, shigella, giardia lamblia, and other such transmitted diseases are still at a high level in our villages. This is a direct result of poor sanitation through inaccessibility of water and unnecessary exposure to human waste. The villagers are knowledgeable about sanitation and hygiene needs, but are often at a loss to put this knowledge to use. Other indirect problems include dental hygiene and increased accident risks, as cited in the example above.

Water is a precious resource in villages. During the summer months, community holding tanks, if available, are filled and residents can fill, from there, their own 30-gallon trash cans and haul them back to their homes. The cans are dipped-from to provide for daily use. Problems are numerous. Contamination occurs at many points, elders and women who cannot carry buckets full of water have no access to it, and the main holding tank pump-houses are in need of constant repair with parts that are not available locally.

During the early 1960's there were public works projects in the villages. However, there are problems with the facilities that were constructed. Local input was seldom sought, and in some cases was disregarded. Customary and traditional land use in the vicinity of water and sanitation facilities was not considered. Construction on permafrost added difficulties. Construction crews from outside the region cut corners on essential design features. Perhaps the worst problems have been that operation and maintenance of the facilities were often ignored. The villagers were left with a lack of adequate training for local operators, and the equipment often requires replacement parts that are difficult to obtain and install.

Adequate funding is essential if the Native Americans in our region are to ever have enough clean water and a system for waste disposal that will give them parity with other Americans for sanitation. Without this, these easily transmitted diseases will continue to plague the villagers, and eliminate their opportunity for improving the overall health status of the community. In addition to adequate funding for projects, we urge you to provide for local control in the design, construction, operation, and maintenance of water and waste disposal systems in Alaska Native communities.

Senator MURKOWSKI. Nina Dahl, Alaska Federation of Natives board, we welcome you to the hearing. Nina, we look forward to your testimony.

Please proceed.

STATEMENT OF NINA DAHL, REPRESENTING THE MANIILAQ ASSOCIATION, KOTZEBUE, ALASKA

Ms. DAHL. I am speaking on behalf of Marie Schwind, who is president of the Maniilaq Association. The Maniilaq Association is situated in Kotzebue, Alaska, which is 30 miles above the Arctic Circle. The Northwest Arctic region spreads out over 36,000 square miles, which we provide health services for. I will read portions of her testimony.

The Maniilaq Association's roots are deep, stretching back to the earliest efforts to win social justice and self-determination for the NANA Region's Inupiat people. The organization was originally launched as the Northwest Alaska Native Association in 1966.

In 1975, the nonprofit organization, now called Maniilaq, merged with the Kotzebue Area Health Corp. and began coordinating a network of community health practitioners, tribal doctors and community clinics, bringing a comprehensive range of health services to surrounding villages. Since then, Maniilaq's range of health services has been expanded to include health education, emergency medical services, eye care, public health nursing, consumer education, and the WIC nutrition program, accident and injury control, environmental health, community health representatives and medical records management. In addition, new programs have been added to Maniilaq's health services division this year called the maternal and child health program.

The Maniilaq Association also funds and manages a number of human and social services programs for the NANA region. These include a group home for young people, an extensive alcoholism program, a women's shelter, mental health counseling, public assistance and social services.

Maniilaq's regional services division contains such diverse programs as regional planning, coastal management, tribal operations, housing improvement, agriculture, employment, and education and media.

The Maniilaq Association has been a staunch supporter of the Inupiat Ilitqusiat movement. This movement is an attempt to revitalize the Inupiat culture throughout our region.

The organization's name has dual significance. First, the man Maniilaq was an Inupiat prophet who traveled and taught throughout the region in the not so far distant days before the first contact with the European world. Maniilaq, in the Inupiat language, also suggests the organization's nonprofit status.

The name has come to symbolize everything the organization stands for: a stalwart commitment to the region and its people; an ongoing agenda of effective community action; the relentless pursuit of regional self-determination; and the hearts and hands of people helping people to help themselves.

I do have written testimony, and it would take more than 5 minutes to read this so I will just leave it as is for you.

Senator MURKOWSKI. Thank you, Nina Dahl. I appreciate your remarks and your entire statement will be entered into the record. We thank you for your testimony.

[The prepared statement follows:]

PREPARED STATEMENT OF THE MANIILAQ ASSOCIATION, PRESENTED BY NINA DAHL ON BEHALF OF MARIE SCHWIND

Hello ladies and gentlemen. I'd like to introduce myself, I am Marie Schwind, President of Maniilaq Association.

Prior to discussion of specific health issues and concerns regarding American Indians/Alaska Natives and the submission of written testimony, I'd like to familiarize you with the scope of the agency I administer.

The Maniilaq Association's roots are deep, stretching back to the earliest efforts to win social justice and self-determination for the NANA Region's Inupiat people. The organization was originally launched as the Northwest Alaska Native Association in 1966.

In 1975, the non-profit organization, now called Maniilaq merged with the Kotzebue Area Health Corporation and began coordinating a network of Community Health Practitioners, tribal doctors and community clinics, bringing a comprehensive range of health services to surrounding villages. Since then, Maniilaq's range of health services has been expanded to include Health Education, Emergency Medical Services, Eye Care, Public health Nursing, Consumer Education, the WIC Nutrition Program, Accident and Injury Control, Environmental Health, Community Health Representatives and Medical Records Management. In addition, a new program has been added to Manillaq's Health Services division this year called the Maternal and Child Health Program.

The Maniilaq Association also funds and manages a number of human and social services programs for the NANA Region. These include a Group Home for young people, and extensive Alcoholism Program, the Women's Shelter, Mental Health Counseling, Public Assistance and Social Services.

Maniilaq's Regional Services Division contains such diverse programs as Regional Planning, Coastal Management Tribal Operations, Housing Improvement, Agriculture, Employment and Education and Media.

In addition, Maniilaq is responsible for the operation of the Kotzebue SSenior Citizens Center and a region wide Homemaker's Assistance program, providing in home assistance for the Elderly and disabled.

The Maniilaq Association has been a staunch supporter of the Inupiat Ilitqusait movement. This movement is an attempt to revitalize the Inupiat culture throughout our region.

Manillaq has been growing rapidly and expanding its activities for the past few years and today the organization coordinates over 30 separate programs and a staff of approximately 155 people.

The organization's name has dual significance, First, the man Maniilaq was an Inupiat prophet who travelled and taught throughout the region in the not-so-distant days before the first contact with the European world. Manillaq, in the Inupiat language, also suggests the organization's non-profit status.

The name has come to symbolize everything the organization stands for: a stalwart commitment to the region and its people, an ongoing agenda of effective community action, the relentless pursuit of regional self-determination and the hearts and hands of people helping people to help themselves.

CONTRACT HEALTH SERVICES TASK FORCE

Three important points to be looked at closely by all American Indians and Alaska Natives:

1. We are opposed to IHS putting out competitive bids for operating our programs. It seems that IHS is trying to get rid of Public Law 93–638 contracting by soliciting bids from nonnative organizations to provide services to American Indians and Alaska Natives.

2. We would like to ensure that the Director of IHS establish a committee composed of representatives from the National Congress of American Indians and the National Indian Health Board to assist IHS in policy analysis and development on a regular periodic basis. The purpose behind this would be to cooperate in IHS

discussion as well as serve as a sounding board for decision making on major IHS policy issues.

3. Although we approve efforts to improve the quality and cost-benefits of Indian Health Care, we oppose the efforts of the Contract Health Services Task Force to tamper with the mission of IHS. This mission is to carry out the federal responsibility to provide comprehensive, high quality health care to American Indian/Alaska Native people, free of individual liability to pay.

COMMUNITY HEALTH REPRESENTATIVE

The Community Health Representative Program was implemented in 1968 to improve the American Indian/Alaska Native people. It was established to promote, support and assist IHS in the delivery of total health care programs. Elimination or decreased funding would remove the primary element in this total health care delivery system, thus losing patient care services not being provided by other health care personnel.

Maniilaq Association supports the position taken by the National Association of Community Health Representatives, Inc., of which six (6) of our CHR's belong to. Maniilaq recommends the following:

A. That future budget negotiation be based on statistically sound data accurately reflecting the services delivered to American Indian/Alaska Communities.

B. Funding for CHR Program be retained at the current funding level of $29 million with eventual provision for adequate cost of living increase.

C. Training of CHR's be specific to Tribal needs.

D. In future budget negotiations, the contract reflects the unique situations, roles and responsibilities under which the Alaska Community Health Representatives perform their duties.

PUBLIC LAW 94-437

Maniilaq Association supports the reauthorization of Title V, P.L. 94-437, the Indian Health Care Improvement Act. This act represents Congress' recognition of federal responsibility for the health care of American Indian/Alaska Native people regardless of where they reside. We as American Indian/Alaska Natives cannot accept a health care status below that of the general population regardless of where our people choose to reside.

AGING ISSUES

Our Alaska Native Elderly were regarded historically as an important resource to our tribal group. Traditionally, they were treated with high regard. Old age was equated with wisdom and learning, it was a period of time when HONOR and RESPECT were bestowed. They performed a variety of important and beneficial roles including instructing the young as well as helping care for children. Elders also maintain responsibility for remembering and relating tribal philosophies, myths, traditions and stories or events peculiar to our tribal groups. They actively support and demonstrate the values and tradition of our tribes while promoting and encourage feelings of cultural pride and identity in young people.

Currently our Elders and the young adults in our region are facing periods of transition. Our changes in culture, lifestyles and traditions have forced us to modify the roles and responsibilities we perform in our various tribal groups.

A number of recommendations have been drafted to address the health care of our Elderly. These include development of a health policy which will adequately address the health needs and concerns of our Elderly and implement services to address these needs.

Many of our Alaska Native Elderly have confidence in and a need for traditional health care from our own tribal medicine persons. Continuing to maintain and encourage cooperative relationships between traditional Tribal Doctors and Western Medicine Professionals are particularly important. Many of our native people do not speak English or are bilingual with a preference for our native language. Provision of bilingual professional and support staff is crucial for improving the health care status of our native people.

Medical and nursing care outside the home is usually costly and often looked upon with disfavor by our Elderly. In spite of the inadequate housing conditions in our villages, the Elderly prefer to receive care within their own homes.

Nursing homes and hospitals should be utilized as a LAST resort, with supportive services, such as homemaker services being made available to our Elderly to allow them to remain at home. When nursing home care is warranted consideration should be given to provisions of tribal-owned and operated homes which make use of culturally specific building designs. With appropriate facilities for family members to sleep over night. Moreover provisions for traditional healing practices, cultural and religious ceremonies and native foods should also be considered.

Special problems of loneliness, inadequate transportation and lack of resources for home maintenance and family support systems are concerns of our Elderly also.

In closing, there are many needs which must be addressed if our people whether they be young or old are to receive the benefit of services which they deserve and from which they could prosper. There certainly is a need to provide health, mental health, recreational and daily living support systems for all American Indians and Alaska Natives.

Senator MURKOWSKI. Mr. Williams, president of Tanana Chiefs Conference, we welcome you to the hearing and wish you a good morning and look forward to your testimony.

STATEMENT OF WILLIAM C. WILLIAMS, PRESIDENT, BOARD OF DIRECTORS, TANANA CHIEFS CONFERENCE, INC.

Mr. WILLIAMS. Thank you, Senator.

My testimony revolves around the administration and the structure of IHS itself. We have seen a lot of improvements in the last few years in Alaska Natives' health, and the efforts of the Government in cooperation and partnership with the Native organizations have begun to develop a viable health delivery system. We strongly urge the continuation of 94–437 to help complete this delivery system, but there are still some basic weaknesses.

Since 93–638 has been enacted, there seem to be a lot of holdovers of the old system. There needs to be a complete new look at the administration and the health delivery systems, incorporating the efforts of the Native corporations more fully into this delivery system. We started out with the "barefoot doctor" type of system. Over the years, a lot of health aides are now getting certification. They are becoming paraprofessionals in their own rights, and each village now has a semblance of at least emergency health care where they can meet emergencies. They do not have to get an airplane into a community and fly somebody to the nearest urban center. That used to sometimes take 4 and 5 days, and there were a lot of unnecessary deaths, suffering, et cetera, because of that.

But, now that we have developed the expertise at the local level, it is time that we stepped back and looked at the whole delivery system. We have to start to decentralize the large bureaucracy that is left of the Government to Indian delivery systems and start looking at the Indian-to-Indian delivery system. The position of the Director of Indian Health Service from the D.C. level on down, we believe, should be an assistant secretary level.

The doors you have to go through to get any firm decisions and actions from the Government take months and sometimes years with the present system and the present structure. The basic one-on-one health planning and the delivery of services to the actual patients at the village level shouldn't take that heavy a bureaucracy to accomplish health delivery. We feel that if we can get an assistant secretary level position in Washington, we will have a better voice for Native health issues in Washington.

We feel that the structures in the State level, a central office level, have never even been looked at since 638 implementation. The staffing levels have remained almost constant. The staffing levels at this office, I think, are like any good bureaucracy: you try to maintain what you have. So, what we are going to have to look at, we have looked at, and we feel they are totally self-serving in the bureaucratic structure.

Our organizations are getting that big that sometimes we even fall into those same traps, but our services are going to have to start to be decentralized. Most of the organizations in the State now are contracting primary health services. We are considering contracting the service unit completely in our area. A lot of the management of the hospitals and clinics in the other areas are done by the nonprofit corporations.

The total planning process of health delivery is now being accomplished by the nonprofit corporations. Fiscal management, at least at the contract level, is being done by the nonprofits. We have oversight, and, yes, the Government should maintain oversight, but what is oversight as compared to maintaining the continued Government structure of health delivery?

I think we really have to look at that closely so we can get the best use of the dollars we are getting.

We have got the numbers. We are going to submit those numbers as testimony to this hearing.

When we first started out in the health contracting business, we were totally left out of some of these structures. We have had to fight many years to get into them. We were totally left out of pay costs, one of the ways of advancing budgets for years. We had to fight to get included in the pay costs. Our budgets were frozen for many years because we were left out of pay cost increases. We were frozen out of many areas of budget increases and given fixed numbers of dollars, and the only way that we could increase our dollars was to increase services. But, when you increase services without the administrative-type dollars going with it, the only place you can put those dollars is directly into programs. Sometimes we put our own delivery services or health services in jeopardy by contracting with the Federal Government. Despite those roadblocks, we have continued to expand our services because we feel that if we are there in the field, we are better able to serve the needs of our own people because we understand those needs.

The Native people have direct control of our organizations, and if we screw up they are able to slap our hands and kick our butts and make us do what they want.

We cannot do that with the present structure of IHS. We need more local control, we need more decentralization, we need more of the decisionmaking done at the local levels.

Sanitation is another area that everybody always harps on. Ever since sanitation in Alaska has been tied to HUD projects, those that are willing to help themselves have been penalized. Unless they can get a big Government-subsidized housing project in their villages, they are left out of the IHS sanitation projects. I know some of our communities that say: "No, we do not want that HUD housing. It has been totally inadequate for years. We have seen what it has done to the other villages, but we would like water and sewer," and the answer has been: "No, you cannot have water and sewer; you do not have a HUD project."

Senator MURKOWSKI. Would you summarize your remarks?

Mr. WILLIAMS. I think that has been a real downfall. Now that HUD's housing program is in a demise situation, maybe we can straighten that out and put water and sewer where it is needed, but keep it in IHS.

And to just summarize, we do strongly encourage reauthorization of the Indian Health Care Improvement Act. We would like to be a partner in this act, and we would like more local control of health issues and health delivery systems.

Senator MURKOWSKI. Thank you very much for that valuable testimony, Mr. Williams. Having observed the formation of the Tanana Chiefs Conference, many, many years ago in working with them through the private sector, I am very aware of the meaningful contribution which you have made and the difficult times that occurred. The responsibility of the Tanana Chiefs Conference has been carried out, and I can certainly speak with some degree of authority that they have done an outstanding job.

[The prepared statement follows:]

PREPARED STATEMENT OF WILLIAM C. "SPUD" WILLIAMS, PRESIDENT, BOARD OF DIRECTORS, TANANA CHIEFS CONFERENCE, INC.

On behalf of the Board of Directors of the Tanana Chiefs Conference I would like to thank Senator Murkowski and Dr. Rhoades for the concern you express for the health care of Native Alaskans by being here today. The Tanana Chiefs Conference, Inc. (TCC) has been providing health services to the Native people of the interior of Alaska in cooperation with IHS since 1974. Since the passage of P.L. 93-638 in 1975, TCC has taken an increasingly active role in the provision of these services with the stated intent of exercising our rights for self-determination by contracting for the management and operation of all Indian Health Service facilities and operations within the Interior Alaska Service Unit. In March of 1983, the full board of directors of the Tanana Chiefs Conference instructed TCC to begin negotiations with IHS to complete the 638 process by contracting for the operation of the remainder of the Service Unit activities provided by IHS. Because of our involvement in the 638 process, and our stated intent to operate the Indian Health Service facility within the TCC region, and because of the progress which Tanana Chiefs Conference has witnessed over the past seven years in the development and provision of IHS services in Alaska, we strongly support the reauthorization of P.L. 94-437.

Even though the Indian Health Care Improvement Act did not fully meet the expectations of the Native people of Alaska because of the lack of resources appropriated for this act, it did provide several very important elements that have stimulated the improvement of Indian Health Services. For the first time it defined the goal to "provide health services to Indians and insure a health status for Indians which are at a parity with health services available to, and the health status of the general population". In addition it stimulated planning for the attainment of this goal by tribal groups throughout the country with the tribal specific health planning process.

This goal and this process have been invaluable for Tanana Chiefs in planning the direction and character of our own health service delivery system over the past seven years.

In addition to the reauthorization of the Indian Health Care Improvement Act, there are several other areas of concern which Tanana Chiefs Conference would like to call to the attention of the committee.

A continuing source of concern, and one which has become particularly acute, due to our current efforts to contract for the remainder of the Service Unit, is the lack of funding for tribal indirect administrative costs. The TCC Board of Directors was informed in March when we stated our intent to contract for the remaining IHS services in our region, by the Alaska Area office, that no funds exist to cover tribal indirect costs and, therefore, services must be reduced to provide administrative overhead if TCC elects to contract for the operation of the remaining IHS services in the region. In the past, the Indian Health Service has provided additional funding for indirect administrative costs to avoid what will be in effect, a financial penalty for 638 contracting, but we have been informed that these funds are no longer available.

When Tanana Chiefs Conference attempted to establish a budget base for contracting, we were informed that only the funds currently in the Service Unit budget would be available. It is the contention of TCC that some funds from the Area office which are expended for the support of provision of care in the Interior Alaska Service Unit, and will never show up in the Service Unit budget, should also be available for contracting. The Area office which has a budget of approximately $7 million, or nine percent of the statewide total, contribute support in the form of direct funding such as catastrophic contract health care coverage, and in the form of in-kind services, such as the services from the Area personnel branch, Area construction and maintenance branch, central warehouse, Area finance, etc.

The Indian Health Service has recently promulgated a draft Indian Self Determination memorandum which softens their position somewhat on the availability of additional funding to support legitimate administrative costs of P.L. 93–638 contractors. This memorandum, however, indicates that the administrative costs negotiated for a particular contract are to be taken out of the same sub, sub activity as the funding for that contract (hospitals and clinics). This would, therefore, not allow for the rational reallocation of resources from Area office program management funds to the contractors administrative cost pool. We, therefore, do not feel that this is the appropriate approach to resolve the persistent problem of adequately funding the administrative cost of P.L. 93–638 contractors.

Tanana Crafts Conference is also gravely concerned about the overall level of resources being provided to the Indian Health Service in the state of Alaska. A recent document completed by the Area office (The Alaska Cost Consideration Study) documents that during the past decade the Alaska Area of the Indian Health Service has received a declining share of overall IHS national resources. This decline, over the past decade, is equal to 3.43% of the national budget, which equates to approximately $21.5 million in FY83, which is over 20% of the Alaska Area budget. The Indian Health Service in Alaska has received this declining share of revenues despite the fact that inflationary costs in Alaska have outpaced those in the U.S. at large substantially in the past few years.

The fact of this decline is made even more alarming by the documentation methodology that the current resource allocation utilized by the Indian Health Service, the resource requirement methodology discriminates against the Alaska Area by the manner in which it is structured. TCC feels it is imperative to address the deficiencies in the resource requirement methodology and correct them to insure that Alaska, an already underserved area, does not continue to receive a smaller share of the already inadequate IHS resources.

Another area of concern and confusion over the past two years has been the proposed elimination of the Community Health Representative program. In Alaska the Community Health Representative has become an essential element of the health delivery team. For the past two years, TCC has been notified that the CHR program would be terminated. This has created a great deal of uncertainty and instability in what was previously an extremely smooth functioning and stable program. The continued uncertainty on the fate of this program has caused many personnel problems with difficulties in recruiting and retaining qualified personnel. In addition, the 20% reduction of the funding of the program two years ago has dramatically decreased our ability to provide needed and necessary health services. The efficiency and effectiveness of the CHR program has been demonstrated and testified to throughout all levels of the Indian Health Service. The Tanana Chiefs Conference would request that the committee continue their support of the CHR program by reinstating it again in the FY84 appropriation.

Another area of concern which has proven increasingly disruptive and expensive, as TCC has gained in contracting experience and expertise, has been the over restrictiveness of certain clauses in the General Provisions of the 638 contracting regulations. To be more specific, clause ten and clause twenty-four, which restrict equipment purchases over $200 and use of consultants costing over $100 a day, to those which have received prior approval of the IHS contracting officer, TCC feels are inappropriate given the current size of our contract and the demonstrated expertise of our management capabilities. Tanana Chiefs Conference currently is providing over $2.3 million worth of IHS contracted health services in the interior of Alaska. When the transition of the remainder of the Service Unit functions is complete, TCC will be providing over $8 million worth of IHS contracted services. Despite the size of this contract and the demonstrated management capabilities of the Tanana Chiefs Conference administration. TCC will still be required to receive prior approval from an IHS contracting official before purchasing equipment or entering into subcontracts. The requirements of these provisions frequently cause long delays and inefficiencies as well as increasing the administrative requirements of providing health services. All of these things tend to increase the cost to the government.

TCC would encourage the IHS to utilize their current authority to waive the requirements of these provisions and provide more realistic limits based on the contractors proven performance as a health care provider and government contractor.

TCC feels strongly that in light of the current economic conditions throughout the country, every effort must be made to provide essential health services in the most efficient and cost effective manner possible. As part of this process TCC feels a commitment to keep administrative cost to a minimum so the maximum amount of funding can go into the provision of direct services. The Tanana Chiefs Conference would urge the IHS to simplify contracting and procurement requirements for 638 contractors to the maximum extent feasible to allow us to keep our indirect cost to a minimum. In addition, the Tanana Chiefs Conference would urge the Indian Health Service to decentralize authority and responsibility and staff to the Service Unit level when ever possible to allow for the provision of the maximum number of appropriate services with the limited funds available.

Thank you.

Senator MURKOWSKI. Our next witness will be Agnes Nichols, vice chairman of Alaska Native Health Board. Agnes, we welcome you to the hearing and look forward to your testimony.

STATEMENT OF AGNES NICHOLS, VICE CHAIRMAN, ALASKA NATIVE HEALTH BOARD

Ms. NICHOLS. I would also like to welcome you.

Senator MURKOWSKI. Thank you.

Ms. NICHOLS. I am so glad that you are able to come here to Alaska instead of transporting every one of us back to Washington, D.C.

Senator MURKOWSKI. I would much rather have that arrangement, too. It is getting hot and sticky in Washington. It is nice to come home. If I may make an observation, the witnesses for the most part here represent, Dr. Rhoades, about 20 percent of Alaska's population. The responsibility which you and I both have in insuring the quality and prompt delivery of health care services is certainly a responsibility that we do not take lightly,

Agnes, we look forward to your testimony.

Ms. NICHOLS. I was also honored, not too long ago, to be part of the task force that Dr. Rhoades brought back to Rockville, Md., and I invited him then to come to Alaska. I hope the next time he comes it will be for a little longer.

Senator MURKOWSKI. Well, he came.

Ms. NICHOLS. My name, of course, is Agnes Nichols, and I am a lifetime resident of the State of Alaska, and I am also chairman of my village council of Eyak, located in Cordova in the Prince William Sound in the Chugach region. I am also a community health representative. I was a charter member of the Anchorage Alaska service unit and Native Board of Health and Alaska Native Health Board. I served 11 years on the service unit board and was its chairman for 3 years. I have also served for 12 years on the Alaska Native Health Board and I am now in the capacity of vice chairman. I am also a mother of 10 children and a consumer of Alaska Native Health Services. All my children were born and raised in Alaska.

In order to give a little history to you, I have a chart here where Alaska is superimposed upon the United States. It goes coast to coast.

Senator MURKOWSKI. That is also to scale, Doctor, and very accurate.

Ms. NICHOLS. Right.

Senator MURKOWSKI. It goes from the east coast to the west coast.

Ms. NICHOLS. And so we thought maybe we might just have an idea here.

The State of Alaska includes 375 million acres of land and 47,300 miles of coastline and spans four time zones. When transposed on a map of the continental United States, Alaska reaches the northern, southern, western, eastern national borders, and of course stretches from coast to coast.

Alaska has a tremendous variation in climate and terrain, ranging from the mountainous maritime environment in Southeastern Alaska to the Arctic plains of the Arctic slope area. The highest point of North America, which is, of course in Alaska, is Mount McKinley or Mount Denali, whichever way you want to put it.

The majority of villages in Alaska are isolated from each other by considerable geographic distances, and are not connected by any highway system. Thus, air transportation is, by necessity, the primary means of travel on the statewide basis. A person in Washington, D.C., who told the North Slope borough to use a bus was kind of wrong there.

Alaska also has the largest air-taxi service in the world, and we also have one of the highest travel fares. For example, round trip air fare from Atka Island on the Aleutian Island chain to a service unit in Anchorage is over $1,000. From Anchorage to Grand Forks, North Dakota, is $662 round trip, so that is a comparison. There are more than 200 Alaska Native communities interspersed within this network of mountains, bays, lakes, tundra, and forest, and medical help in this environment can be an hour away or a week, depending on the weather, availability of travel, and the season of the year. Severe storms can hamper travel, either by boat or by plane.

Bringing the history to you of the Alaska Native health care system would take more than 5 minutes, but I will try to put into a capsule.

Senator MURKOWSKI. You have about 3 minutes, Agnes.

Ms. NICHOLS. OK. My speech, I timed it, was 4½ minutes.

The health care system went through three distinct periods of Alaska Native health care which were separate but overlapping: The first being the pre-contact period when Alaska Natives enjoyed relatively high standards of health and during which the Alaska Natives' societies developed a variety of medical health practices tied to their culture, their religion, and the ecology systems; the second period was characterized by the introduction of disease to the Natives, decimating many populations, as in the Prince William Sound where a great percentage of the villagers died because of smallpox and influenza. Venereal disease was also introduced, and the inevitable white sugar was also introduced to the populace. This period swept back and forth for at least 200 years, and during this period the Federal Government began its involvement in caring for the Alaska Native people.

In the mid-fifties, the level of health care had reached its lowest peak. A federally sponsored report, the Parran Report, minced no words in blaming inadequate medical care for what it called "the slow death of a once proud and self-sufficient race."

The third period began with the transfer of Federal Native health care to the U.S. Public Health Service, and public health programs were set up. The Alaska Native Claims Settlement Act also set up 12 regional organizations and consequently 12 regional health entities. The largest and most sophisticated hospital in this system is the Alaska Native Medical Center here in Anchorage. Not only is it unique in its capacity as a referral hospital for the rest of the State, but it is also the meeting place for the folks from back home.

In 1968, the Alaska Area Native Health Service opened its Office of Native Affairs which set up both statewide and regional Native health boards. The statewide health board eventually became the health arm of the Alaska Federation of Natives. After years of growing pains and final recognition by Indian Health Service with the memorandum of agreement which was signed in Washington, D.C., the Alaska Native Health Board received recognition.

In 1973, the Alaska Native Health Board was reorganized and included a member from the 12 regional health boards. Its mission was to elevate the health delivery system to its ultimate level, and be advocate and voice for the Native peoples.

Some positive accomplishments within the past 10 years were the closing of the TB wing at ANMC, and winning over otitis media, the ear disease prevalent that in 1957, 17 percent of Alaska children were afflicted by the disease, and by 1970, 67 percent of this group were afflicted by age 4. Chronic ear disease was then the greatest cause of Alaska Native morbidity. By 1975, 3,000 surgeries were performed with reported good results. Dr. Martha Wilson was one of the persons who began the effort to screen and rehabilitate these children. There have been many pioneers in the medical field dedicated and concerned about the health of the Native peoples.

The establishment of the Indian Health Care Improvement Act which was signed into law in 1976 was a significant plus to the Alaska Native health care system.

Now, if there were adequate personnel, the unmet health needs would be addressed. Construction and renovation of needed facilities and unmet needs for safe water and sanitation would be recognized too. Even with these hopes, the ultimate level has still not been reached, and this act should be reauthorized. ANHB still addresses, and its members still advocate for needed contract health moneys, travel moneys, the funding of CHR's, and involvement in the State health plan.

Our health system is unique. One human response came from an able seaman who came to ANMC when it was a public health hospital and served seamen, and this person was also a dependent of a Native man. The quote was: "They treated me as a human being, and where else could an able seaman have a hysterectomy?"

Thank you.

Senator Murkowski. I do not know.

Our next witness is Kenneth Charlie, Chairman, Alaska Native Health Board.

Mr. Charlie. Thank you.

Senator Murkowski. We look forward to your testimony, Kenneth. We thank you, Agnes, for your very valuable testimony.

Please proceed.

STATEMENT OF KENNETH CHARLIE, CHAIRMAN, ALASKA NATIVE HEALTH BOARD

Mr. Charlie. My name is Kenneth Charlie, and I am chairman of the Alaska Native Health Board and resident of the Tanana Chiefs region.

This morning, we would like to offer testimony on behalf of the Alaska Native Health Board. A lot of the information that we have here shows the significant differences between the non-Natives and the Natives of Alaska as far as health is concerned or health-related issues.

Alaska Natives are disproportionately represented in the State's morbidity and mortality statistics. Health indicators verify that morbidity and mortality rates must be greatly reduced to reach the level of other Alaskans and the general U.S. population.

Decreasing Native mortality rates and improving the general health status is a challenge due to outstanding demographic and geographic impediments. The village lifestyle is characterized by low socioeconomic levels, few employment opportunities, poor sanitation or water supplies and a traditional subsistence economy.

Alaska Natives are people in transition between two polarized cultures, and the stress of that lifestyle is evidenced through the high mortality and morbidity rates. Alaska Natives comprise only 16 percent of the State's population but 28 percent of the State's mortality, whereas non-Natives make up 84 percent of the population and only 72 percent of the mortality.

Accidents are the leading cause of Native mortality. Also, the Native mortality rate for accidents is three times the rate for non-Natives. Heart disease and hypertension are the second leading cause of mortality, 1½ times that of the non-Native mortality. Alaska Native infant mortality still remains several percentages points higher than that of non-Natives. Overall mortality rates for Alaska Native men is twice that of Alaska Native women. Also, mortality rates for Natives ages 15 to 34 account for nearly one-third of all Native mortality in all age groups.

Hospital data, discharge and in-patient days show accidents, alcohol abuse and heart disease to be the leading health problems for Alaska Natives. Accidents are still the leading cause of hospitalizations in IHS facilities. The number of accident patients has increased 33.5 percent since fiscal year 1980, and hospital data show a 79.4 percent increase for the 2-year period between fiscal year 1979 and 1981. Six facilities reported accidents as the leading cause of hospitalization, and one facility reported heart disease as the leading cause of hospitalization.

The information that we have here, as I stated earlier—like the in-patient days required to treat accidents and the diagnosis time for in-patient times, in-patient days for prenatal conditions, alcohol abuse—seems to indicate that more in-patient days are required.

Just in closing, I would like to state that it is important to recognize that a large share of the health problems afflicting Alaska Natives are potentially preventable. This includes most accidents, cancers related to smoking and industrial contaminants, heart disease and hypertension, alcoholism, homicide and suicide.

We thank you for this time that we have had to share with you, the things that concern.our people in Alaska.

Senator **Murkowski**. Thank you very much, Kenneth Charlie. We appreciate your testimony and that of all the witnesses this morning. I think it has been very valuable and meaningful in the record.

I would like to ask two questions of anyone that would care to respond. What do you feel is probably the greatest unmet health need of the Alaska Native population at the present time? If you were going to prioritize them, what is the greatest problem that needs the most immediate attention?

Ms. **Nichols**. The Alaska Native Health Board has rated alcoholism as No. 1.

Senator **Murkowski**. Then drug abuse?

Ms. **Nichols**. And then the No. 2 health problem is the Hepatitis B, influenza.

Senator **Murkowski**. I assume you all generally agree with that?

Do you have any input to add on the planned construction of safe water and sewage disposal systems with regard to technologies that may be dictated but are impractical in the bush? You can often make a decision locally that is much more practical than somebody in Washington who dictates the manner in which these particular projects are engineered. I have heard criticism from time to time that some of the approaches are not practical, they are extremely expensive, they do not work, and you would be better off to implement practical systems that would provide the service at much less cost.

Mr. **Williams**. I would like to tackle part of that.

Senator **Murkowski**. Go ahead, Mr. Williams.

Mr. **Williams**. With regard to those issues, we seem to be caught on the horns of a dilemma. Yes, the economy of scale of an urban water sewer system does not seem to be practical in rural villages. The cost to maintain those systems once they are built and turned over to a very small community with no tax base, and no economic base, makes them almost impossible to operate and function and maintain those systems. But again, without those systems, when you look at the health point of view what are your options? We have gone from the honey buckets to the outhouses to the full-blown underground systems, and we all realize that the running water and proper sewage was at one time one of the factors that helped us to alleviate many of the major health problems and the communicable disease problems in the villages. Still they are very expensive to maintain and the villages don't have the resources to maintain those facilities.

But do we just abandon them and go back to the honey buckets and then start the communicable diseases problems and the problems that come with open sewage and poor water? Do we go back to that?

Senator **Murkowski**. There is no halfway.

Mr. **Williams**. There is no halfway in the present-day technology; there is no present-day technology where it is cheap to take a crap. It is expensive.

Senator **Murkowski**. Thank you. With that we will thank the witnesses for the testimony and move on to the next panel.

We thank you all, and again I would remind you that the record will be open for 30 days and you may submit any further remarks at your convenience, and we do thank you.

Panel No. 2, is made up of regional health directors. I call Bill Dann or Eddie del Rosario. Bill Dann is from Nome, and Eddie is from Bethel; David Mather, health director, Tanana Chiefs Conference; Elise Patkotak, executive director, North Slope Borough Health and Social Services Agency; Robert Clark, Bristol Bay Area Health Corp.; Niles Cesar, executive director, Southeast Alaska Regional Health Corp.

While we are seating the witnesses, I would like to introduce a couple of other people: Pat Edwards manages our Anchorage office, and we certainly appreciate her efforts to put this hearing together this morning. She worked with many others.

Elise Patkotak, executive director, North Slope Borough Health and Social Service Agency, we welcome you to the hearing. We are looking forward to your testimony.

Please proceed, and I would again remind you that I am going to adhere to the 5-minute limit.

STATEMENT OF ELISE PATKOTAK, EXECUTIVE DIRECTOR, NORTH SLOPE BOROUGH HEALTH AND SOCIAL SERVICES AGENCY, ACCOMPANIED BY EDUARDO DEL ROSARIO OF THE YUKON-KUSKOKWIM HEALTH CORP.

Ms. **Patkotak**. Before I start, I would just like to comment that Niles Cesar could not make it, so Billie Peters will be reading his testimony into the record, and a gentleman from Norton Sound will be reading Bill Dann's testimony. He also could not make it.

I would like to speak today about IHS, Indian Health Service contract management and area administration from the 638 contractors' perspective. The view of the Alaska Area Office's management and administration of 638 contracts by its contractors can perhaps be best expressed by the old adage "too many cooks spoil the soup". It has been one of the particular frustrations of the Alaska 638 contractors that they frequently have more people impacting their contracts from the area office than they have employees providing service. This type of situation leads to management nightmares as the contractor tries to cope with and please an ever-changing cast of characters that tends to group in circles so that it is sometimes impossible to find the final authority. Invariably when a problem arises and is unresolved over many months and much correspondence, the inevitable statement is put forth, "You are not talking to the right person."

This phrase now holds all the credibility of that ever famous "Your check is in the mail" statement.

Consistent with this top-heavy contract management in the area office is the problem of obtaining adequate indirect administrative costs that enable the contractor to perform the services required. When 638 contracting first started, we were told that the area office could not split off a part of a position and provide the corporation with the equivalent dollar amount that fraction represented in administrative support.

However, 10 years later, the situation now is quite different. Bristol Bay Area Health Corp. has taken over the Dillingham Hospital, Norton Sound now operates the Nome Hospital. Tanana Chiefs in Southeast Alaska Health Corp. are assuming responsibilities for the IHS clinics, the North Slope Borough is moving toward takeover of the Barrow IHS facility. With direct responsibilities for these facilities removed from the area office, it would seem that at some point we should see a decrease of area administrative staff and a concomitant increase of those previously committed dollars being made available to the corporations now providing the services.

Another reason frequently given for the amount of management personnel in the area office relates to the need for people who can oversee the contract development negotiations each year. What is rarely mentioned and even more rarely proposed to the regional health corporations is the idea of a 3-year contract. Most corporations have a core of programs that they have been operating for many years but have little to no yearly change. The dollars available for these programs may change 10 to 20 percent in either a plus or minus direction in any given year, but are basically stable. These contracts are ideally executed for 3-year terms.

By eliminating the yearly time consuming effort of renegotiating a contract in substance, and having the dollar amount remain basically unchanged, IHS could justify a reduction in its management force and allow those freed-up dollars to flow into 638 contracts to start addressing unmet needs. Maintaining a yearly negotiation renewal leads to a wasting of the dollars available in what is essentially a parrot-like exercise that could be phoned in. With no new dollars available, no major program changes and no contract points to be negotiated, the yearly exercise can be eliminated.

Another issue that arises in relation to the extent of the scrutiny and oversight most contractors must live with is the basic question of whether tribal contractors are the right hand of their tribal government or the left hand of the Federal Government. Attempts to play both roles lead to the paranoia that sometimes seems predominant in the personality of many health directors.

Health corporations feel that their major objective is to address the health needs of their population as expressed by that population. This cannot occur when they are viewed by IHS as an IHS employment agency in any given region. The restrictions placed on our contracts allows little to no freedom to do anything different than IHS would do. On top of this, we are constantly impacted with amendments, up to 18 in any given year, that make contract management a nightmare and health care delivery almost secondary to keeping the paperwork straight.

The Alaska Native health corporations have proven themselves capable of providing a regional health care delivery system to all parts of this State, from urban areas to the smallest village. No centralized bureaucracy, be it the Federal or State Government, has ever been able to achieve the same results.

In order to continue these services, we need IHS cooperation at an area level. The contracting system must be streamlined, and the area office needs to address its top-heavy management load. It is both unjust and financially impossible for regional health corporations to manage services for IHS unless IHS provides the management dollars and cooperation necessary. The health corporations in this State are mature programs that do not need "Big Brother" constantly scrutinizing them.

There comes a time when every child grows up and accepts responsibility for his or her own life. This time has arrived for Alaska Native health corporations. Our management record is proof of this. IHS must now allow us to stand on our own two feet. Under the present IHS management system, which seems to be based on how many people IHS can possibly justify, regardless of the actual workload, this is impossible.

I have attached two addendums to my written testimony that are area office documents to show the type of administration we must respond to for our contract work.

If no new dollars can be made available for health care, then we must take the best possible use of those we have. The time is now to streamline management and redirect those dollars in direct service delivery.

Senator **Murkowski**. Thank you very much. Elise, I appreciate your staying within the time limits and your testimony was very meaningful. You people in the delivery business really are doing an outstanding job under more very difficult circumstances.

We are going to move right along. I understand Bill Dann is not here.

Mr. **Del Rosario**. Yes, Bill Dann is not here, Senator Murkowski, but I would like a few minutes to make this oral presentation here.

Senator **Murkowski**. That is fine. What is your name?

Mr. **Del Rosario**. I am Eddie del Rosario.

Senator **Murkowski**. From Bethel?

Mr. **Del Rosario**. From Bethel Y.K.H.C.

Senator **Murkowski**. We will take Bill Dann's testimony and submit it into the record as if read, and we would ask you to proceed with your own testimony, Eddie.

Mr. **Del Rosario**. Thank you very much, Senator.

Good morning, everyone. I work as the director of the community health aide program and the health education program for the people of the Yukon-Kuskokwim Delta Region through the Native health corporation, Y.K.H.C. I have an M.D. degree from the Philippines and an M.P.H. from Johns Hopkins University in Baltimore. I consider myself both a practitioner and a lifetime student of public health. I was attracted to work in Bethel and its surrounding villages because of its commonality with the Third World countries from whence I came. I am an immigrant to the Y. K. region just like the 15 percent of the non-Native population of the region. I feel that I can view the situation here with an objective pair of eyes.

The last time I was invited to testify to a similarly distinguished group was Independence Day of 1979 in Guam when a congressional select committee heard our testimonies on Guam's horrendous drug abuse problem. It was a time of great crisis then—as it is now here in Alaska.

I am sure some of the people here in this room today have read the article entitled "America's Indians: 'Beggars in Our Own Land' " in the May 23 issue of the U.S. News & World Report. In that same issue, the editor wrote about the stinging rebuke of our Government's policies and an eloquent plea that was made to address the problems and redress past and present grievances of the poorest ethnic minority group in this great land. The author of this plea was your esteemed colleague, Senator Barry Goldwater of Arizona. I would venture a guess that the decent people of this world are as appalled as any of us to read about the "First Americans who are still at the bottom of the ladder—high in unemployment, health problems and alcoholism; low in wealth and education". The White House solution is a classic: slash the funds for Indian programs next year by $353 million, half a billion less than in 1982. I am sure that some of the enemies of the United States will say "I told you so," to the American Indians. The truth is, more than 100 years of Federal programs have not improved the lives of Indians and Alaskan Natives. They see themselves as victims of decades of Government neglect and wrongheaded policy, as well as victims of broken promises and misplaced trust. All 371 treaties, they feel, were either violated, broken or modified to their great disadvantage. Some angry voices even claim a U.S. Government's hidden agenda of ultimate termination and racial annihilation of the American Natives, premeditated genocide without firing a single bullet.

Now, these are very serious and strong accusations, and I'm sorry I have to say this here today. These policies and practices are also powerful forces that prove to be genuine obstacles toward the achievement of good health. Although they are political in nature and mostly man-made, they enhance the harmful effects of naturally occurring germs and other environmental factors. They also negate or blunt the beneficial effects of modern medicine and public health measures.

The result: horrendous and shameful health statistics which every American in good conscience should never find acceptable. These beggars in their own original land called Indians and Alaskan Natives die in the following rates in comparison to all races in the United States of America, a country which is well known to the rest of the world as a leader and a mecca of modern health care.

Indians and Alaskan Natives die 3.2 times more of accidents than other Americans; 7.7 times more due to alcoholism; 2½ times more due to homocide; twice more due to pneumonia and influenza; 2.2 times more due to a diabetes; almost twice more due to suicide; almost 6½ times more due to tuberculosis, and we can go on and on.

These are national figures averaged out to show you the health status of an aggregate group of people. Hiding behind these statistics are worse horror stories representing pockets of extreme hardships, anguish, hopelessness, and diseases. One could easily mistake them for health statistics coming out of my native country, the Philippines, or for example Bangladesh, and most of the African nations.

One Native leader had this to say about the scourge of alcoholism here in Alaska:

> When a people start on a course for self-destruct, they have given up hope; they have lost their reason for living.

In the Y.K. region, for example, we have our own examples, but I'll just submit this because of the time. I would just like to tell the panel here that over in the Y.K. region, we do have the poorest socioeconomic status. We are not proud of this statistic that we have, and we are not proud of the list of superlatives we lay claim on, but they are still facts. We have the worst health problems, the lowest per capita health expenditures of the seven Alaska service units, the harshest terrain and environment, the least and the worst road system, the lowest paid community health aides and other primary health care providers, and probably the lowest quality of life index.

I pay tribute and express great admiration for the people of southwestern Alaska to have endured such conditions for so long, but how long can they survive? I've talked to some Native people who have said that it hurts them to think that they might be forced to compete for the scarce almighty dollar with their brothers elsewhere just to improve their lot. It runs counter to their cultural tradition of putting others ahead of oneself, but here we're talking of basic survival. They ask—and this is under a regime of an economic order which is alien to their way of life to begin with—"Why isn't there enough for everybody?" After all, they were promised by the Federal Government that there would be more than enough for everybody to share equitably.

I pose the same question to you today, Senator Murkowski and Dr. Rhoades. We are in total support of the reauthorization of the Indian Health Care Improvement Act. There seem to be some problems with 638, and we wish that some of these problems would be addressed more closely.

Thank you very much, Senator.

Senator **Murkowski**. Thank you very much, Mr. del Rosario. I appreciate your testimony.

[The prepared statement and accompanying material follow. Testimony resumes on p. 62.]

YUKON-KUSKOKWIM HEALTH CORPORATION

P.O. Box 528
Bethel, Alaska 99559
(907) 543-3321

- TESTIMONY TO THE SENATE SELECT COMMITTEE ON ALASKAN AND NATIVE AMERICAN HEALTH CARE - June 3, 1983, Anchorage, Alaska, U.S.A.

GOOD MORNING, HONORABLE GENTLEMEN OF THE U.S. SENATE. I AM MOST HONORED TO BE HERE TODAY TO OFFER MY TESTIMONY.

MY NAME IS EDUARDO DEL ROSARIO AND I WORK AS THE DIRECTOR OF THE COMMUNITY HEALTH AIDE PROGRAM AND THE HEALTH EDUCATION PROGRAM FOR THE PEOPLE OF THE YUKON-KUSKOKWIM DELTA REGION THROUGH THE NATIVE HEALTH CORPORATION, Y.K.H.C. I HAVE AN M.D. DEGREE FROM THE PHILIPPINES AND AN M.P.H. FROM JOHNS HOPKINS UNIVERSITY. I CONSIDER MYSELF BOTH AS A PRACTITIONER AND A LIFETIME STUDENT OF PUBLIC HEALTH. I WAS ATTRACTED TO WORK IN BETHEL AND ITS SURROUNDING VILLAGES BECAUSE OF ITS COMMONALITY WITH THE THIRD WORLD COUNTRIES FROM WHENCE I CAME FROM. I AM AN IMMIGRANT TO THE Y-K REGION JUST LIKE THE 15% OF THE NON-NATIVE POPULATION OF THE REGION. I FEEL THAT I CAN VIEW THE SITUATION THERE WITH AN OBJECTIVE PAIR OF EYES.

THE LAST TIME I WAS INVITED TO TESTIFY TO A SIMILARLY DISTINGUISHED GROUP WAS INDEPENDENCE DAY OF 1979 IN GUAM WHEN A CONGRESSIONAL SELECT COMMITTEE HEARD OUR TESTIMONIES ON GUAM'S HORRENDOUS DRUG ABUSE PROBLEM. IT WAS A TIME OF GREAT CRISIS THEN - AS IT IS NOW HERE IN ALASKA.

I AM SURE MOST OF THE PEOPLE IN THIS ROOM TODAY HAVE READ THE ARTICLE ENTITLED "AMERICA'S INDIANS: "BEGGARS IN OUR OWN LAND" IN THE MAY 23rd ISSUE OF THE U.S. NEWS & WORLD REPORT. IN THAT SAME ISSUE, THE EDITOR WROTE ABOUT THE STINGING REBUKE OF OUR GOVERNMENT'S POLICIES AND AN ELOQUENT PLEA TO ADDRESS THE PROBLEMS AND REDRESS PAST AND PRESENT GRIEVANCES OF THE POOREST ETHNIC MINORITY GROUP IN THIS GREAT LAND BY YOUR ESTEEMED COLLEAGUE, SENATOR GOLDWATER OF ARIZONA. I WOULD VENTURE A GUESS THAT THE DECENT PEOPLE OF THIS WORLD ARE AS APPALLED AS MANY OF US TO READ ABOUT THE "FIRST AMERICANS WHO ARE STILL AT THE BOTTOM OF THE LADDER - HIGH IN UNEMPLOYMENT, HEALTH PROBLEMS AND ALCOHOLISM; LOW IN WEALTH AND EDUCATION". THE WHITE HOUSE SOLUTION IS A CLASSIC - SLASH THE FUNDS FOR INDIAN PROGRAMS NEXT YEAR BY $353 MILLION, HALF A BILLION LESS THAN IN 1982! THE UNITED NATIONS DECOLONIZATION COMMITTEE AND OTHER UNFRIENDLY FORCES IN THIS WORLD WOULD SURELY GLOAT WITH GLEE AND SAY TO THE AMERICAN NATIVES, " I TOLD YOU SO". I WOULD NOT BE SURPRISED TO SEE THEM SPORTING BUMPER STICKERS PROCLAIMING "SAVE THE U.S. - TERMINATE AN AMERICAN NATIVE TRIBE TODAY".

THE TRUTH IS MORE THAN 100 YEARS OF FEDERAL PROGRAMS HAVE NOT IMPROVED THE LIVES OF INDIANS AND ALASKAN NATIVES. THEY SEE THEMSELVES AS VICTIMS OF DECADES OF GOVT. NEGLECT AND WRONGHEADED POLICIES AS WELL AS VICTIMS OF BROKEN PROMISES AND MISPLACED TRUST. ALL 371 TREATIES, THEY FEEL, WERE EITHER VIOLATED, BROKEN OR MODIFIED TO THEIR GREAT DISADVANTAGE. SOME ANGRY VOICES EVEN CLAIM A U.S. GOVT.'S HIDDEN AGENDA OF ULTIMATE TERMINATION AND RACIAL ANNIHILATION OF THE AMERICAN NATIVES - PREMEDITATED GENOCIDE WITHOUT FIRING A SINGLE BULLET. NOW THESE ARE VERY SERIOUS AND STRONG ACCUSATIONS. THESE POLICIES AND PRACTICES ARE ALSO POWERFUL FORCES THAT PROVE TO BE GENUINE OBSTACLES TOWARD THE ACHIEVEMENT OF GOOD HEALTH. ALTHOUGH POLITICAL IN NATURE AND MOSTLY MAN-MADE, THEY ENHANCE THE HARMFUL EFFECTS OF NATURALLY-OCCURING GERMS AND OTHER ENVIRONMENTAL FACTORS. THEY ALCO NEGATE OR BLUNT THE BENEFICIAL EFFECTS OF MODERN MEDICINE AND PUBLIC HEALTH MEASURES. THE RESULT: HORRENDOUS AND SHAMEFUL HEALTH STATISTICS WHICH EVERY AMERICAN, IN GOOD CONSCIENCE, SHOULD NEVER FIND ACCEPTABLE. THESE "BEGGARS IN THEIR OWN ORIGINAL LAND" CALLED INDIANS AND ALASKAN NATIVES DIE IN THE FOLLOWING RATES IN COMPARISON TO ALL RACES IN THE UNITED STATES OF AMERICA, A COUNTRY WELL-KNOWN TO THE REST OF THE WORLD AS A LEADER AND MECCA OF MODERN HEALTH CARE:

1. INDIANS AND ALASKAN NATIVES DIE 3.2 X MORE OF ACCIDENTS THAN OTHER AMERICANS
2. 7.7 TIMES MORE DUE TO ALCOHOLISM
3. 2½ TIMES MORE DUE TO HOMICIDE
4. TWICE MORE DUE TO PNEUMONIA AND INFLUENZA
5. 2.2 TIMES MORE DUE TO DIABETES
6. ALMOST TWICE MORE DUE TO SUICIDE
7. ALMOST 6½ TIMES MORE DUE TO TUBERCULOSIS

THESE ARE NATIONAL FIGURES AVERAGED OUT TO SHOW THE HEALTH STATUS OF AN AGGREGATE NUMBER OF PEOPLE. HIDING BEHIND THESE STATISTICS ARE WORSE HORROR STORIES REPRESENTING POCKETS OF EXTREME HARDSHIPS, ANGUISH, HOPELESSNESS AND DISEASES. ONE COULD EASILY MISTAKE THEM FOR HEALTH STATISTICS COMING OUT OF THE PHILIPPINES, BANGLADESH, EL SALVADOR OR MOST AFRICAN NATIONS. ONE NATIVE LEADER HAD THIS TO SAY ABOUT THE SCOURGE OF ALCOHOLISM: " WHEN A PEOPLE START ON A COURSE FOR SELF-DESTRUCT, THEY'VE GIVEN UP HOPE; THEY'VE LOST THEIR REASON FOR LIVING".

IN THE Y-K REGION FOR EXAMPLE, THE ONLY EVIDENCE THAT YOU ARE IN THE UNITED STATES AND NOT IN A THIRD WORLD COUNTRY ARE THE U.S. FLAGS THAT YOU SEE FLUTTERING AROUND AND THE GREEN DOLLARS THAT EXCHANGE HANDS. IF OUR RATES FOR THE PREVALENCE

OF HEPATITIS -B AND OTHER INFECTIOUS DISEASES ALONE CAN BE CONVERTED TO DOLLARS, OUR PEOPLE WILL SURELY HAVE THE HIGHEST PER CAPITA INCOME IN THE ENTIRE U.S. THE GOVERNOR OF ALASKA IS WELL AWARE OF THE LIST OF SUPERLATIVES WE LAY CLAIM ON IN SOUTHWESTERN ALASKA - SUPERLATIVES WHICH WE DON'T CARE TO ADVERTIZE BUT WHICH WE FEEL VERY IMPORTANT FOR YOU TO KNOW:

1. THE POOREST SOCIOECONOMIC STATUS
2. THE WORST HEALTH PROBLEMS
3. THE LOWEST PERCAPITA HEALTH EXPENDITURES OF THE 7 ALASKA SERVICE UNITS
4. THE HARSHEST TERRAIN AND ENVIRONMENT
5. THE LEAST AND THE WORST ROAD SYSTEM
6. THE LOWEST-PAID COMMUNITY HEALTH AIDES AND OTHER PRIMARY HEALTH CARE PROVIDERS
7. PROBABLY THE LOWEST QUALITY OF LIFE INDEX

I PAY TRIBUTE AND EXPRESS GREAT ADMIRATION FOR THE PEOPLE OF SOUTHWESTERN ALASKA TO HAVE ENDURED SUCH CONDITIONS FOR SO LONG BUT HOW LONG CAN THEY SURVIVE? I'VE TALKED TO SOME NATIVE PEOPLE WHO HAVE SAID THAT IT HURTS THEM TO THINK THAT THEY MIGHT BE FORCED TO COMPETE FOR THE SCARCE ALMIGHTY DOLLAR WITH THEIR BROTHERS ELSEWHERE TO IMPROVE THEIR LOT. IT RUNS COUNTER TO THEIR CULTURAL TRADITION OF PUTTING OTHERS AHEAD OF ONESELF. BUT HERE WE'RE TALKING OF BASIC SURVIVAL UNDER A REGIME OF AN ECONOMIC ORDER WHICH IS ALIEN TO THEIR WAY OF LIFE. THEY ASK, "WHY ISN'T THERE ENOUGH FOR EVERYBODY"? AFTER ALL THEY WERE PROMISED BY THE FEDERAL GOVT. THAT THERE WOULD BE MORE THAN ENOUGH FOR EVERYBODY TO SHARE EQUITABLY. I POSE THE SAME QUESTION TO YOU TODAY, HONORABLE GENTLEMEN.

WE CAN NOT MAINTAIN ACCEPTABLE LEVELS IN THE QUALITY AND QUANTITY OF MUCH-NEEDED MEDICAL CARE IN OUR REGION IF FUNDING KEEPS ERODING, NOR CAN WE SUSTAIN MORE FUNDING CUTS LEST OUR PROGRAMS BE DOOMED TO INEFFECTIVENESS OR EXTINCTION. THE VIRULENT GERMS WE HAVE TO FIGHT EVERYDAY WAITS FOR NO MAN NOR DOES IT KNOW HOW TO REST AND TO FIGHT FAIRLY WHILE WE WAIT FOR SUPPLEMENTAL BUDGETS. EVERY DOLLAR LOST FOR HEALTH CARE AND COMMUNITY DEVELOPMENT ADDS ANOTHER NUMBER TO OUR GROWING STATISTICS OF DEATH, DISEASE AND DISABILITY. I ASK OF YOU MOST SINCERELY, " ISN'T IT ABOUT TIME TO STOP RUBBING SALT INTO THESE PEOPLE'S WOUNDS"? TO PARAPHRASE SENATOR GOLDWATER, " THE TREATMENT OF INDIANS IS NOT JUST A QUESTION OF HUMAN RIGHTS BUT ALSO OF MORAL OBLIGATIONS. LET'S ESTABLISH SOMETHING IN OUR OWN BACKYARD THAT WE CAN BEGIN TO BE PROUD OF BEFORE WE WANDER AROUND THIS EARTH TRYING TO TEACH OTHER PEOPLE HOW TO LIVE AND HOW

TO ACT TOWARD EACH OTHER. LET'S ACT TOWARD EACH OTHER IN THIS COUNTRY LIKE WE REALLY MEANT WHAT WE TALK ABOUT."

HONORABLE GENTLEMEN, SEVENTEEN THOUSAND PEOPLE IN THE YUKON-KUSKOKWIM REGION AWAIT YOUR ACTIONS. I, TOGETHER WITH THE BILLIONS OF PEOPLE IN THE THIRD WORLD WHO ARE WATCHING, AM CURIOUS TO FIND OUT HOW YOU WILL CONTINUE TO TREAT YOUR BROTHERS AND SISTERS. IS IT WITH OPEN ARMS OR THE BACK OF YOUR HAND? IS IT HELP WILLINGLY GIVEN AND WITH DIGNITY OR IS IT ALMS FOR A BEGGAR GIVEN GRUDGINGLY? " AMERICA, AMERICA, GOD SHED HIS GRACE ON THEE. AND CROWN THY GOOD WITH BROTHERHOOD..." - IS THIS SONG BASED ON TRUTH, OR IS IT JUST PROPAGANDA?

THANK YOU VERY MUCH FOR YOUR ATTENTION.

YUKON-KUSKOKWIM HEALTH CORPORATION
P. O. Box 528
Bethel, Alaska 99559
(907)543-3321

MEMORANDUM

TO: George Peratrovich **DATE:** May 9, 1983

FROM: Marilyn Chohaney

SUBJECT: Comments on Sandra Borbridge's letter of April 28, 1983

I believe that it would be appropriate for YKHC to participate in the hearings on rural health care costs on May 19 or 25. It's hard to tell from this letter exactly what is needed from us, however. I think what Sandra is-asking is that we forward her information that will support the position that rural Alaskan health care delivery is expensive, difficult, and dependent on transportation factors. I judge from her letter that it is not necessary for any of us to personally travel to Juneau or Washington, D. C., but that State of Alaska DHSS will represent our concerns.

As far as providing factual information to support this position regarding rural Alaskan health care needs, I have no data available. ; would imagine that SCHPD has such information, and possible PHS, since it has just examined its costs for the new billing system.

One bit of information we might offer would be the approximate cost of a patient visit to a village CHA. This could be obtained by dividing the total YKHC CHAP budget plus PHS clinic lease money plus PHS village supply costs plus village council contributions by the total number of patient encounters, all for FY'82. I'm sure Ed has this information available.

PHS might be able to supply dollar figures or expenditures for emergency travel for FY'82. PHS and the Bethel Family Clinic might also speak to the difficulty in recruiting health care professionals to the area.

I wonder whether PHS staff here would be allowed to speak on these issues at a congressional hearing, however. I think not. That may mean that, if YKHC wishes to participate in this hearing, we may have to represent the total viewpoint of health care here, including PHS concerns.

MC

MC:amc

cc: Joe Ryan
Trotter

BILL SHEFFIELD
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

April 28, 1983

Mr. George Peratrovich
Yukon-Kuskokwim Health Corporation
P.O. Box 528
Bethel, AK 99559

Dear George:

John Tabor of the Governor's Office in Washington, D.C. has informed us that the Senate Labor and Human Resources Committee will hold hearings on health care costs on May 19 and 25. He felt this would be a good opportunity for the State to submit testimony concerning the high health care costs in the state, the difficulty in recruiting health care professionals to the state, the problems and cost of transporting people long distances to receive health care, etc.

I mentioned this hearing at the Alaska Native Health Board meeting in Anchorage April 13, and many organizations expressed an interest in providing us with information. As the Staff Assistant for Rural Affairs, I would like to request your assistance in providing information to the Governor's Office on the high cost of rural health care. As an organization closely involved with rural health care, and with expertise gained through service to a large area of the state, your assistance is not only valuable, but very necessary.

I will be working with the Department of Health and Social Services, through Special Staff Assistant Allen Blume, in providing information for the testimony. Should you have any questions or concerns, please feel free to call me.

Sincerely,

Sandra J. Borbridge
Special Staff Assistant
to the Governor

YUKON-KUSKOKWIM HEALTH CORPORATION

P.O. Box 528
Bethel, Alaska 99559
(907) 543-3321

May 10, 1983

Sandra J. Borbridge
Special Staff Assistant
to the Governor
Pouch A
Juneau, Alaska 99811

Dear Sandra:

Here is our response to your letter of April 28, 1983, requesting information concerning high health care costs in Alaska and the difficulty in recruiting health care professionals to our region, and the problems and cost of transporting people long distance to receive health care.

1. YKHC provides services to 48 villages plus Bethel.
2. There are approximately 16,000 to 18,000 people in this area.
3. Our region covers 100,000 square miles.
4. There is no road system connecting the villages.
5. The harsh terrain and environment often dictates the method and time of travel.
6. This corporation has documented that the YKHC region has in relation to the other native regions.
    a) The poorest socioeconomic status.
    b) The worst health problems
    c) The largest number of villages.
    d) The largest native population.
    e) The third largest service area.
    f) The third highest cost of doing business
    g) The lowest per capita health expenditures of the seven Alaska Service Units.
7. The hospital no longer has funds for patient travel creating extreme hardships for the village people.
8. The communication system are very sporadic and very bad at times.

9. Higher infant mortality than the U.S. as a whole.
10. High incidence of alcoholism, accidents, Otitis Media, Strep, V.D., infectious hepatitis, T.B., anemia and dental disease.
11. The YKDR Hospital is very limited in what it can provide in transporting referral patients to ANMC.

I hope this information will be helpful to you, and if you need anything else please feel free to call me.

Sincerely,

George Peratrovich

George Peratrovich
Executive Director, Y.K.H.C.

GP:amc

cc: File

YUKON-KUSKOKWIM HEALTH CORPORATION

P. O. Box 528
Bethel, Alaska 99559
(907) 543-3321

MEMORANDUM

TO: GEORGE PERATROVICH, Executive Director DATE: May 20, 1983

FROM: Eddie R. del Rosario, AHD

SUBJECT: Points to ponder/Questions to ask about CHAP and Health Ed., Re- Senate Select Committee Hearing on Indian Health Care Improvement Act

The upbeat mood reflected in these programs at the end of CY '82 seemed to sour as news of impending funding cuts both from IHS and State started turning to reality. I have always perceived myself generally as optimistic but come budget time, I can't seem to shake the blues - especially when the budget ceiling turns to concrete and the budget floor turns to rubber or even is pulled from under me at times.

In general, I'm worried sick about the future concerning my two programs especially as it relates to the quality and quantity of direct and indirect health care provided to the villagers. The important issues that would seriously impact on either quality or quantity of health care provision, or both, as they relate to either HAS or H.Ed. or both, as I see them, are the following:

1. Unstable funding sources from both Fed. and State sectors which are on a downward trend and appear to be in a continuing backslide. IHS funding cut of 5% for FY '83 from FY '82 level actually meant an effective cut of 15% to 20% when inflationary costs and maintenance of parity relative to usual budget increases in the past are factored in. For my two programs, that translates to at least $224,269; in terms of services, it means 11,213 less patient-encounters, down 12.5% from FY'82 levels. It also translates to a substantial degree of dissatisfaction and insecurity among our employees especially our front-liners, the CHAs in the villages who are grossly underpaid, overworked and sometimes unappreciated. Each valuable, trained and experienced CHA we lose means an immediate $15,000 loss to our corporation (this only represents training cost to certification level) and an estimated average loss to the village of $27,000 worth of direct medical services per year (based on est. cost of $20/patient-encounter for an average total of 1,345 patient-encounters/CHA per year). If looked at another way where each patient has to be transported to and serviced at the Bethel hospital for an average conservative cost of $200 per patient-encounter, we're talking of big money to the tune of more than $250,000 per year added to our region's total health care cost for every certified CHA we lose!

QUESTIONS: a) Can we, in good conscience, afford this to happen (we meaning YKHC, IHS and the State)?

b) What are the hidden costs and implications not only in dollar terms but in terms of human lives and quality of life in our villages?

2. Competition within the present health care system: rather than discuss this, let me ask these questions: a) Why are our CHAs the lowest-paid in the whole State of Alaska? (Average earning for CY '82= $10,622 per annum)

b) Why are our CHAs the lowest-paid among all the health care providers in our region? (Our Medical Director's salary plus fringes amount to $71,495 per annum, 7 times the average CHAs yearly earnings; HAT director's salary plus fringes amount to $54,000 per annum, 5 times the average CHA's yearly earnings; a PHN earns 4 to 5 times more than a CHA).

c) Why is it that the wages in Alaska's medical industry averaged a yearly gain of 28.5% for the past ten years while our CHA's wages lagged far behind?

d)Why has Statewide CHAP funding by IHS remained at about 5% of total outlays (based on FY '81 funding level) while hospitals consumed 49% of the funds? In Y-K region, CHAP funding is about 12% of total IHS outlay of $12 million for FY '83 while the hospital has 66% of total, yet, the CHAs had 80,000+ patient-encounters (65% of total) while the hospital had only 44,000+ patient-encounters (35% of total). A physician earns 4 to 6 times more than a CHA with a host of fringes and privileges while just a little more than 2 times more productive than a CHA on the average. I realize that these comparisons may be called invalid by some people but one indisputable fact remains - there is a least common denominator that one can not escape to face and that is, both CHA and physician exist to save people's lives and to ease human pain and miseries. I submit that both are equally doing a fine job yet the rate of compensation for each one relative to the other is grossly unfair and glaringly unequal!

e) Why does IHS only allow a shameful 0.2% of total funds for health education while "miscellaneous programs and support" budget category, whatever they are, get 2.3% of total funds? Even satellite communication category get 0.9%. It seems that priority-wise, health education is less important than satellite communication or even "miscellaneous programs"! I would imagine that even lip service alone would cost more than 0.2% of total funds. In fact, it cost more than 7% of total funds (Total Program Management from Area office was budgeted for a whopping $6.6 million for FY '81).

3. Lack of unified health policies between Federal and State as it relates to bush Alaska. I have only addressed two of our programs and it is obvious that from the above, our region can not maintain acceptable levels in the quality and quantity of needed medical care if funding keeps eroding, nor can it sustain more funding cuts lest our programs be doomed to extinction or ineffectiveness. Even during the "golden years" of secure funding when IHS budget, on the average, was getting a 14% annual increase, the Federal native health care program has never achieved parity with the funding levels necessary to even just maintain health, let alone improving the health status of the Alaskan Natives to approximate or equal that of Alaska's white population or that of the lower 48's general population. From the number of animal hospitals I've seen in California, I suspect that their cats and dogs enjoy better medical care than the Natives of Alaska. I suspect too that the Indians and Eskimos in Northern Canada and Greenland are far better off healthwise than is true here in Alaska. This should be a cause for national shame. I question the true level of concern of the Federal Government for the health and welfare of the Alaska natives. If we can not expect any help from the Reagan administration, why does Congress condone his actions when it knows so well what needs to be done to meet the Federal Government's basic responsibilities and sworn promises towards the Native Americans?

Can relief be found in the Federal Courts? Does it have to reach the point of litigation for the Fed. Govt. to answer to its obligations? What do we have to do to get national attention to our plight and to prick the conscience of the American people down South? Are we to be reduced to beggars before the Federal Govt. decide to throw some scraps to us to save our health programs which are just beginning to reap rewards for our people? To the Alaska natives, the only "safety net" I know of is the frozen, barren tundra or the tractless waste of snow and ice beneath their feet which have no known nutritional value that I know of and thus can not sustain human life. Through Federal neglect and the unrelenting onslaught of "White men's diseases", I doubt that there will be enough Alaskan natives left to watch the spring break-up in the year 2000 when the rest of the world will be celebrating "Health Care For All

Day" sponsored by the World Health Organization. That will be the saddest day for the few remaining "Brown Alaskan-Americans" who placed the greatest of faith and trust on the "Great White Father".

My final question here is what about the State Govt.? What role will it take in health care financing in the face of Fed. Govt.'s seemingly inevitable retreat from the scene? Would perhaps a new Federal-State partnership revitalize the sagging future of the health care system in the bush? I have grave doubts about the State Govt.'s willingness or ability to come to the rescue of bush Alaska because of rural Alaska's lack of political clout. This is one time I sincerely hope I'm proven wrong.

4. Alternatives to consider when funding reaches critical levels:

a) To cut costs, close down some village clinics and maintain only strategic ones or cluster them together into small decentralized administrative units.

b)Identify and train more Area Health Aides to do Supervisor-Instructor functions in their neighboring villages; replace S/Is with these AHAs.

c) Employ more mid-level practitioners with expanded duties and responsibilities in Bethel hospital and subregional clinics. Skilled surgeons and internists (a few good ones) should be hired to replace G.P.s.

d) Teach more skills to CHAs to allow for expanded duties and responsibilities in order to reduce costly referrals.

e) Clinic admission fee for everybody.

f) Fee for service extended to village clinics for non-beneficiaries.

g) Explore ways and means for CHAs to recover third-party payments.

h) Vigorous encouragement of village councils to assume more responsibilities in funding for CHA salaries and clinic support.

i) Identify and press back into service other village health care practitioners such as traditional healers, herb doctors, traditional birth attendants, ex-CHAs, etc.

j) Strengthen health promotion and disease prevention activities; encourage self-help, self-care, "back to basics" activities as they relate to health, sickness, nutrition, shelter, and safety.

k) Provide as much secondary care in village setting as much as possible and practicable; involve family members in provision of such care in order to cut down on costly hospital-based and ancillary care.

l) Prioritize health care needs to allow for cost-cutting according to cost-benefit criteria.

If we are to talk about what we really need in the area of primary health care and health education, funding cuts should immediately stop. An immediate infusion of 35% more money based on our current FY '83 funding level is imperative in order to restore us on an even keel. Subsequent funding levels should allow for at least 15% annual increase for the next five years or more with the goal of achieving parity with actual needs at a minimum.

FROM FY-81 TO FY -83 IN ORDER TO STAY WITHIN OUR BUDGET WE HAVE HAD TO CUT BACK ON A NUMBER OF SERVICES SUCH AS:

1. PATIENT TRAVEL - WE PAY FOR EMERGENCIES ONLY, AND THAT IS ONLY IF THE PATIENT IS UNABLE TO PAY OR THE CITY COUNCIL.

2. PERSONNEL - LAPSED 14 POSITIONS.

3. TRAINING - CME FOR PHYSICIANS ONLY.

4
- DEPARTMENTAL BUDGETING- WE HAVE SET UP SUPPLY BUDGETS FOR EACH DEPARTMENT AND SEE THAT THEY STAY WITHIN THAT BUDGET.

5. WE HAVE REDUCED NON EMERGENT SERVILES TO NON BENS PRIOR TO OPENING OF THE NEW CLINIC. SINCE THEN, POLICY SUPERCEDED BY ALTERNATE RESOURCES.

6. WE NO LONGER SUPPORT THE BOARDING HOMES.

7. WE NO LONGER PICK UP PATIENTS FROM TOWN OR THE AIRPORT OR PAY FOR THEIR CAB FARE.

8. WE DO NO T PAY FOR TRANSPORTATION TO ANCHORAGE FOR ELECTIVE DIAGNOSTIC OR THERAPEUTIC PROCEDURES FOR BENEFICIARIES.

9. RESTRICTED USE OF EXPENSIVE MEDICATIONS IN HOSPITAL FORMULARY AND HAVE SET
AANHS PEHL
SORRY FOR INTERFERENCE (TO CONTINURE)
9. RESTRICTED US E OF EXPENSIVE MEDICATIONS IN HPITAL FORMULARY, -, AND HAVE SET STRICT MEDIAL CRITERIA FOR LA B AND X RAY CALL BACK.

10 TRIED TO LIMIT FIELD CLINIC SH SCHEDULES TO SCHEDULED AIRLINES ONLY 0- NO CHARTERS

11 STOPPED ROUTINE SPORTS PHYSICALS FOR SCHOOLS AND THE REGION.

G
12 HAVE RESTRICTED DEFINITION OF WHOSE ELIGIBLE FOR NON EMERGENT CARE AT THEHOSPITAL.

13 #HAVE BEEN AGGRESSIVE IN IMPLEMENTING BILLING PROCEDURES FOR NON BENS IN ORDER TO INCREASE REVENUE FOR THEHOSPITAL.

THE ONLY REASON THAT THE PEDIATRIC WING WAS CLOSED WAS DUE TO THE SHORTAGE OF NURSES - INABILITY TO RECRUIT AND RETAIN NURSES.

AT PRESENT WE HAVE 156.5 AUTHORIZED POSITIONS OUT OF WHICH 27 POSITIONS ARE PRESENTLY VACANT. OUT OF THESE, 10 -ARE NURSING POSITIONS.

THANK-YOU

END 2:46PM WED MAY 25, 1983

Following is a list of more cut-backs to add to list put ~~set~~ yesterday.

The Pharmacy pre-packs all items such as penicillin, dicloxacill, aspirin, etc. Also prepackages own normal saline nose drops instead of buying them prepackaged.

The Poisindex system in outpatient medicine room will no longer be updated. The system costs 1300 dollars per year. The Iowa Drug information system whic contains articles on drugs and diseases on microfische will also be discontin Cost $900 for updates per year.

Autorefill screened and limited to those persons who without their medicines regularly may deteriorate to the point of disability or even death.

Animals will no longer be given any medications from the Pharmacy.

Urinary tract infections which are uncomplicated that in the physicians judgement can be treated with single dose therapy will be so treated as often as possible.

Education of Community Health Aides regarding autorefill to eliminate waste, and rotating stock in villages and sending back short-dated supplies so that the Bethel Pharmacy can use them before they expire.

IV's held until word received from physician to eliminate wastage from antibiotics and other drugs that are given IV because of late orders.

Special orders on drugs ordered only in life threatening situations.

LAB: Lab has been doing more lab procedures here instead of sending them to Smith Cline lab.

Started batching some chemistries - Now run 3 times per week instead of once a day and in this way saves reagents.

Inventory is done each month on entire stock and set up ordering system with individual people responsible for certain sections. This keeps from overstoc and prevents emergency ordering.

Made Physicians aware of Lab procedure costs so now they screen more carefull and order cheaper procedures.

OTHER: Training for all other employees limited to tuitiion and fees. Employ bear cost of Travel and Per diem.

Combined YKHC Board and Hospital Health Board, thereby saving added expense o separate meetings.

Cut back ESP's except for absolute emergencies.

Stopped selling meal tickets to outpatients.

Central Warehouse issue books checked carefully and items not really needed taken out. Also State PHN's asked to provide paper for XXXXXXXXXXXX Copier in exchange for use.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION

ALASKA AREA NATIVE HEALTH SERVICE
YUKON KUSKOKWIM
DELTA REGIONAL HOSPITAL
BETHEL, ALASKA 99559

October 26, 1981

HEALTH CARE SERVICES REDUCTIONS

Introduction:

The medical staff and administration of the Yukon Kuskokwim Delta Regional Hospital are dedicated to the provision of comprehensive, quality health services and access to those services by all the people of the Delta, but regretfully due to severe budget constraints and staffing shortages the following changes in services provided will have to be made in order to provide adequate care for acute illnesses. We are hopeful that some of these changes will only be temporary; that other sources of revenue can be tapped: that staffing levels can be restored; and, that adequate access to health care can be assured. However, in the present climate of federal spending cuts we are frankly pessimistic that previous federal spending levels will be attained in the near future. We are anxious to work with the community in enlisting further help from local, regional, state and federal agencies to meet the health care needs of the people of the Yukon Kuskokwim Delta.

In the meantime the following policies will be in effect:

HEALTH CARE SERVICES REDUCTION

Patient Travel:

a. Village Travel.

Patient travel authorizations from the Villages will only be granted to beneficiaries with medical emergencies who cannot arrange to pay for their own travel. A medical emergency will be defined as an acute illness or injury which requires medical attention within less than 24-48 hours in order to prevent death or significant disability. It is assumed that this care cannot be adequately obtained in the Village. The decision as to what constitutes an emergency will be made by a physician in consultation with the Community Health Aide. The hospital will only pay for travel authorized by a physician. Travel will not be automatically authorized for these emergency conditions; patients will be expected to pay for their travel if they can afford it. Travel from Bethel to the Village cannot be considered an emergency need and will no longer be paid for by the hospital.

Two exceptions to the above guidelines will be made:

1. Cancer patients who cannot afford to pay for their travel will be authorized as necessary for palliative or therapeutic treatment.

2. Health Aides who are requested by a physician to travel with a patient because of the seriousness of the medical condition, will continue to have their round-trip travel paid for.

HEALTH CARE SERVICES REDUCTION

Patient Travel: (Con't)

B. Anchorage Travel.

Patients will be expected to pay their round-trip air fare to Anchorage in the event that medical evaluation or treatment is required there. If it is an emergency condition which would likely result in death or significant disability if not evaluated or treated in Anchorage within a short time, and the beneficiary cannot affort to pay for travel, the hospital will, of course, try to help out within the limits of our resources.

Boarding Homes:

The hospital does not have the money to continue to pay for boarding home services for patients, though we feel this is an essential need. Patients needing to stay in town overnight for medical reasons will have to stay with friends, relatives, or in boarding homes at their own expense. (Currently about $15.00 per night). The hospital will continue to try to help patients make boarding arrangements.

Village Field Clinics:

Physicians travel to the Villages for field clinics will be cut in half. The hospital will pay for one physician field visit per village per year. We will continue to try to allow physicians time in their schedules to permit them to either stay longer in the Village on each visit, or return for a second visit if the Village is willing to pay for the physician's

HEALTH CARE SERVICES REDUCTION

Village Field Clinics: (con't)

travel. This should be arranged between the respective Village physicians and Village councils.

Hospital Staffing:

In order to balance the personnel budget it has been necessary on a local level to freeze hiring for all currently vacant positions (approximately 36 positions). This includes personnel who are needed for direct patient care, including doctors and nurses. Some departments are spread thin. This may mean longer waiting periods in Outpatient for "walk-ins" to see a doctor, or longer waiting periods for patients to receive an appointment. It means that until five new registered nurses can be hired to relieve the current severe nursing shortage, we will continue to be forced to operate pediatric and adult inpatient wards at one-half of capacity (approximately 20 beds instead of 40). We are hopeful of significanly increasing medicaid/medicare collections to provide additional revenues in 2-4 months to allow us to begin filling these critical vacancies. It is very important that we have the staff necessary to open all 40 beds and function at full capacity.

A further obstacle to hiring critically need personnel (other than present lack of money) is an IHS wide hiring freeze applying to all personnel categories including direct patient care. Exceptions to this freeze must be requested in writing on an

HEALTH CARE SERVICES REDUCTION

Hospital Staffing: (Con't)

individual basis and be approved by Area and National Headquarters before that individual can be hired. This freeze is partly to allow other PHS Personnel an opportunity to redistribute themselves within IHS since many have lost current jobs with the closure of PHS Hospitals in the States. The freeze is also partly in anticipation of further budget cuts by the Reagan administration this fiscal year.

Non-Beneficiary Care:

According to regulations, "Limited Outpatient or short term hospitilization may be provided but excluded one elective surgery - extensive - diagnostic studies". In the past we usually offered greater benefits than those and this has represented a significant drain on resources for several reasons. Due to antiquated rates, we have only been able to charge non-beneficiaries a fraction of what each outpatient visit or costs the hospital. We do not have the local or Area authority to change those rates. IHS is in the process of adjusting rates to be more commensurate with costs and substantial increases in rates can be expected in the future for Outpatient services. Nevertheless, regardless of these eventual rate adjustments, services to non-beneficiaries can be expected to be reduced as increasingly limited resources are focused on priorities of the IHS mission.

HEALTH CARE SERVICES REDUCTION

Non-Benficiary Care: (Con't)

The IHS staff feels it is important that the restriction of care to non-beneficiaries still be loosely applied. However, if in the future we are unable to recover a more significant portion of the costs of non-beneficiary care through increased billings and collections, or if there are further budget cuts, it can be anticipated that non-beneficiary health care services will be further curtailed. The community would be wise to anticipate the need for private physicians in Bethel.

Outpatient Services:

In the meantime, the hospital will no longer provide non-acute care to non-beneficiaries. We will continue to see and treat acute medical problems related to infection, trauma and other acute problems. (This includes: Strep Throats, otitis media, fever, pneumonia, venereal disease, lacerations, fractures, etc.). Chronic problems will have to referred to Anchorage for evaluation and treatment. (MCH will continue to provide family planning services). Non-beneficiaries will not be able to make appointments, but will have to wait and be seen by the Walk-In doctor. Employment physicals and flight physicals will not be available. Non-prescription medications (such as: cough syrups, decongestants, aspririn, tylenol, etc.) will not be provided. Patients will have to pick these up at local stores. Short courses of prescription medi-

HEALTH CARE SERVICES REDUCTION

Outpatient Services: (Con't)

cations will be provided for the treatment of acute problems as medically indicated. Chronic medications will have to be obtained from Anchorage as is the present policy.

Inpatient Services:

Non-beneficiaries requiring hospitalization will be referred to private physicians and facilities in Anchorage unless hospitalization is required to stabilize or treat the patient prior to transfer. This will be handled on an individual basis.

Pregancies:

An exception to the above rules will be observed regarding pregnancies. For the time being, we will continue to see women for routine prenatal care and deliveries as before.

Hospital Employees:

Policy regarding non-beneficiaries will also apply to civil service hospital employees except as specified within Employee health policy.

Sports Physicals:

The hospital staff will not assist in the performance of routine sports physicals for the schools either in Bethel or the Villages. The medical staff feels that this requirement is without sufficient medical indication to justify the diversion of limited health care resources from the delivery

HEALTH CARE SERVICES REDUCTION

Sports Physicals: (Con't)

of higher priority acute care. The requirement for yearly physical examinations for all students wishing to participate in sports is an unrealistic goal in the context of unmet acute care needs and limited health care resources. If the State and the schools wish to make this a requirement, whether for the purpose of student health and safety or liability coverage, they will have to provide the personnel to perform the examinations.

Ambulance Services:

The Indian Health Service provided some start-up monies for the local ambulance services and some inital operative funds. It was clearly stated that this was a limited committment and that further operating funds would have to be obtained from other sources. The hospital is now unable to provide any further support for the ambulance including money for the transport of critically ill patients to and from the airport. If the ambulance service is to survive, costs will have to be billed and collected from individual patients, including native beneficiaries of IHS. Patients not requiring an ambulance will have to provide for their own transportation to and from the hospital; a hospital driver will not be generally available.

HEALTH CARE SERVICES REDUCTION

Conclusion:

The hospital Staff recognizes that these reductions in services are drastic. They represent desperate measures to stay within budget constraints. These measures considerably affect access to health care for beneficiaries and non-beneficiaries. They will impose significant hardships on the people of the Delta. These measures considerably affect the practice of medicine here and are both painful and disagreeable to the Staff. Hopefully, local, regional, and state agencies will step in to fill the huge gaps left by insufficient federal funding. Hopefully, other resources and innovative solutions will be found and the impending hardships will be transient. The Staff is anxious to work with the community to assure quality, comprehensive health care to all the people of the Yukon Kuskokwim Delta.

Senator MURKOWSKI. The next witness is Mr. David Mather who is the health director of the Tanana Chiefs Conference. Mr. Mather, we welcome you to the witness chair and look forward to your testimony and would ask that you proceed.

Mr. MATHER. Thank you. On behalf of the board of directors, I would like to enter some written testimony into the record.

Senator MURKOWSKI. Your entire testimony will be entered into the record as read.

STATEMENT OF DAVID MATHER, HEALTH DIRECTOR, TANANA CHIEFS CONFERENCE

Mr. MATHER. Thank you. First, the Tanana Chiefs Conference does strongly support the reauthorization of the Indian Health Care Improvement Act. In 1975, Lillie McGarvey, testifying on behalf of the Alaska Health Board, to the Senate subcommittee on the original authorization of the act, said that it was the answer to our prayers.

Well, I am not sure it ended up being an answer to our prayers because of the lack of resources that were put into the act, but I do feel that there were several important elements of the act that provided an impetus to dramatically improve the health care delivery in the State. The act did provide additional resources in some areas, specifically in health manpower. Although a small number, we have had individuals who have utilized these resources. The act reaffirmed the commitment on the part of the Federal Government to provide health services so that Native individuals might be able to obtain a parity with the health status of the rest of the American individuals throughout the county. This is a set of goals that the health corporations could strive for.

In addition, the act provided funds and encouraged tribal governments to develop a planning process which has been, I believe, instrumental in allowing many of the tribes to progress through the 638 self-determination mechanism over the past 3 or 4 years, and we strongly support the reauthorization of the act.

We do have several other concerns, however, which we would like to address here. I guess the primary one is the diminution of resources which have been put into Indian health care nationwide over the past 2 to 3 years. Since 1980, there has been a decline in the real resources available in Alaska for several reasons. One of these reasons, we believe, is that inflation in Alaska has continued at an unabated pace, whereas in the lower 48, inflation has slacked off, and we have suffered the penalty because of this. What has compounded this problem is that we feel that the share of the national Indian Health Service resources which has been provided to Alaska has decreased fairly dramatically over the last decade. In 1973, the Alaska area had approximately 19 percent of the resources that were going nationwide in Indian health care; in 1983, 10 years later, we find this has decreased by over 3 percent of the national resources, which would translate to over $21 million in statewide resources.

Now, this is a 20-percent reduction from what we would have had if we maintained parity with the other areas of the country inside IHS.

We feel that this is a very serious situation that needs to be redressed.

Perhaps even more important is the fact that the current methodology which IHS has adopted to distribute resources discriminates dramatically against Alaska and the Alaska area, so——

Senator MURKOWSKI. How?

Mr. MATHER. Well, the first thing is that the population estimate which the resource requirement methodology uses sets the population at 65,000 for Alaska's IHS's official population; the Native Claims Settlement Act rolls were over 80,000. With documentable national population increases, we can show in between 85,000 and 90,000; so there's a 25-percent population penalty right there. In addition, the resource allocation methodology does not include such things as travel which is excessively expensive in the Alaska area. In the past 2 years, the Alaska area has had to reduce their patient travel budget by over 35 percent because of the dramatic reductions, and at the same time travel costs in the State have inflated over 24 percent, so you're looking at a 50-percent reduction in resources.

Senator MURKOWSKI. Thank you.

Mr. MATHER. This does not include facility support cost as a separate item, heating costs, maintenance costs. You yourself as an Alaskan know these are excessive, especially in bush regions, and the IHS does have a large inventory of facilities in bush Alaska. These are not factored into the analysis clearly, and we feel that there is a very dangerous downward spiral of resources allocated to Alaska. We do not feel there can be any change to that, and so the actual methodology which the Indian Health Service utilizes has to be changed.

The other areas which are routinely underestimated are the salary costs for the community health aide program. The methodology does not include a realistic estimate of those costs, so we would ask the committee and Dr. Rhoades to undertake an analysis of the resource requirement methodology and do something to solve this disparity. That concludes my testimony.

Senator MURKOWSKI. Thank you very much. We appreciate that very valuable testimony.

[The prepared statement follows:]

RECEIVED JUN 13 1983

Tanana IRA Council
Tanana, Alaska

Patricia Zell
Senate Select Committee on Indian Affairs
Dirksen Senate Office Building
Washington, D.C. 20510

Attention: Indian Health Care Improvement Act - Senate Oversight Committee

Dear Ms. Zell:

The Tanana IRA Council would like to offer testimony regarding Indian Health Service programs and services in the Interior Alaska Service Unit of the Alaska Area of Indian Health Service. We would appreciate it if the following information can be made a part of the Oversight Hearing record:

> The Tanana IRA Native Council and the Tribal Health Task Force would like to express grave concerns about the status of health care available to rural Alaskan Natives and about the future of Indian Health Service in general. The recent recommendations by the Director's Task Force on Contract Health Care are particularly disturbing to us because we are dependent solely on contract health inpatient care as a result of the closure of the ANHS Tanana Hospital last fall. It now appears that access to those contract health services may become even more severely limited.
>
> We believe that the Indian Health Care Improvement Act made two particularly important statements. 1) It established accreditation by appropriate agencies as a goal for existing IHS facilities. 2) It differentiated between rural and urban Indian and Alaska Native programs. It is our understanding that the Indian Health Care Improvement Act was an important directive to Indian Health Service to raise the standards of care available to Indians and Alaska Natives to the existing and accepted "state of the art" as measured by accreditation standards. We also believe that the Act restated a basic premise; that Indian Health Service was established to provide health care facilities where none exist -- in the traditional tribal or village settings or on reservations which are rural, remote, and often lack the economic base to attract private practitioners or to develop private medical facilities. We feel that these priorities have been forgotten in the Interior Alaska Service Unit.
>
> In the Interior Alaska Service Unit, the focus has shifted from upgrading village facilities and access to medical services by rural villagers, to expanding the urban ANHS Clinic at Fairbanks. The Fairbanks ANHS Clinic, which began as a small storefront operation less than ten years ago, is now a wing of the privately owned Fairbanks Memorial Hospital. The Fairbanks ANHS Clinic supports four physicians, a physician's assistant, a full dental clinic, three pharmacists and a score of nurses and support personnel in addition to the full administrative and clerical staff of the Service Unit. The contractual agreements between the IHS clinic and the private hospital and the interpersonal and professional relationships between the clinic and hospital staff paved the way for the increasing referral of patients to Fairbanks Memorial Hospital rather than to the Indian Health Service Hospital at Tanana. The utilization shift away from the Tanana Hospital was deliberate and planned to justify the closure of the hospital. An obvious reason being that the Service Unit Director preferred to live in the urban Fairbanks area as did several members of the professional staff. The non-native urban professional planners of the Tanana Chiefs Regional Health Corporation (also based in Fairbanks) endorsed the closure of the Tanana Hospital with little regard to the wishes of the village people of the Alaskan Interior, and despite the fact that petitions from thirty Interior Alaska villages were received by both Tanana Chiefs Health Corporation and Indian Health Service stressing the importance of a village-based hospital for village people and asking that Tanana Hospital not be closed.

The Tanana Hospital was always portrayed in official memoranda as an "aging wood-frame structure", the implication being that the hospital was unsafe and a maintenance nightmare. Actually the hospital was built in the early 1950's and while certainly a candidate for future replacement (a fact outlined in the body of the Indian Health Care Improvement Act), the hospital met all lifesafety codes and was fully accredited by JCAH with laboratory accreditation by CAP at the time of the closure. The JCAH survey team during the last survey cited the Tanana hospital for having fewer deficiencies than any other IHS facility in Alaska. The hospital provided quality acute and recuperative care in a non-stressful and familiar setting. In comparison, many of the village elders who must now travel to Fairbanks to receive medical care find themselves lost and bewildered in a highly stressful urban setting. Many village elders do not know how to make a telephone call; cannot summon a taxi; do not understand the precesses of paperwork; do not understand appointment or referral systems; do not understand the urban medical practices and systems through which they pass. The support systems to explain the unfamilair and ease fears do not exist at Fairbanks Memorial Hospital the way they do at IHS hospitals. The village people of the Alaskan Interior are reduced to numbers in the impersonal urban medical system.

It is readily apparent that Alaska Native Health Care priorities in the Interior Alaska Service Unit are defined by the needs of the professional and administrative employees rather than by the needs of the people for which Indian Health Service was created to serve.

The Fairbanks ANHS Clinic exists at the expense of the remainder of the Service Unit. There are no physicians assigned to any village clinic; physician field trips to the village clinics average one per year and often the village is asked to pay the travel expenses of the physician on that visit. Village Health Aides cope with the bulk of medical problems and emergencies. Nurse Practitioners or Physicians Assistants are assigned to the Fort Yukon and Tanana clinics and the Service Unit Director has many times stated that Nurse Practitioners and Physicians Assistants are "better trained" to work in village clinic than are physicians. This unsupervised practice of medicine by mid-level physician extenders is not accepted by standard-setting and accreditation agencies. Certainly the presence of a Health Aide, PA, or Nurse Practitioner is preferable to having no health care providers at all, but it is our belief that these mid-level practitioners should have the full supervision and support of qualified physicians to the greatest possible degree. We do not think that occasional radio or telephone contact is sufficient and we would take the position that the physicians stationed at the Fairbanks ANHS Clinic should be reassigned to sub-regional clinics and to a schedule of travel that would take them to villages on a bi-monthly or at least quarterly basis. Too many serious health problems are not being detected or resolved by the physician extenders working in the village clinics either because of a lack of specialized training or because they lack modern medical support in the form of radiology and laboratory services required to make diagnosis.

In the Interior Alaska Service Unit there exist two seperate and distinct philosophies of health care. One applies to the health care to be delivered to the urban population via the Fairbanks ANHS Clinic which is to be "state of the art" and to that end, the clinic staff is striving to meet accreditation standards. The second philosophy applies to the people who live in the villages which makes no pretence reaching toward accreditable standards of patient care. The attitude toward village medical care could be characterized as "bandage if bleeding". We would like to relate some of the specific instances that demonstrate the plight of the Athabaskan people who remain in their traditional villages.

-The outpatient clinic left behind at Tanana after the closure of the Tanana Hospital is located in the oldest building on the hospital compound, a small single-family house. A portable x-ray unit stands unshielded in a corner bedroom. The modern laboratory equipment from the hospital lab has been shipped out to other Alaska Area IHS hospitals leaving a makeshift laboratory in the former kitchen of the clinic house. What little bacteriology that is done is done in the same room that is used to receive emergency trauma patients...within three feet of where patients receive stitches. Medical records are stored in a closet with sliding wood doors; the configuration of the clinic and thin walls make privacy impossible. When concerns were raised by several members of Native Council regarding the incubation of bacteria in the same room where bandaging and wound treatment are done, Dr. Ward Hurlburt, a member of the Medical Audit team stated that the bacteria posed no threat; that he had special training in infection control and could assure us that these were the same bacteria that we breath in every day. This type of simplistic and inaccurate answer reflects the lack of concern for implementing Health Care Improvement for the rural people of Alaska.

-Too many people in Tanana and other Interior villages are dying of malignancies that are not diagnosed until too late to treat despite the fact that the victims have sought early treatment for symptoms. Much more needs to be done to research the instances of cancer among Alaska Natives.

-There is far too much indiscriminate prescription of antibiotics. A patient who is treated by a village health aide or by the practitioner at one of the sub-regional clinics may often receive a prescription for ampicillin to treat a sinus or ear infection. Often no specimens are taken for culture and there is no evidence that the antibiotic prescribed is effective against the infective organism. There is, for example, documented evidence of a high incidence of Hemophilus occuring in this area causing a variety of symptoms such as sinus infection, ear infection, sore throats, rhinitis, etc. If ampicillin is prescribed for hemophilus which does not respond to ampicillin, not only does the patient not get well, but the development of ampicillin-resistent pathogens is encouraged. Accreditation agencies recognize such problems and require antibiotic utilization studies to combat their indiscriminate useage.

-There is a lack of access to basic medical care providers. An elderly lady of this village has suffered for some time from gastric distress; pain, nausea, vomiting. She is finally referred to the Fairbanks ANHS Clinic to be examined by the Internist on staff there. She has no funds; is not employed; is not enrolled in any State welfare program and therefor is not a Medicaid recipient. The staff at the Tanana IHS Clinic tell her that she has an appointment in Fairbanks on a certain day. How she gets to Fairbanks is up to her. Indian Health Service will not pay her transportation costs because she is not 1) Pregnant and in her last trimester of pregnancy. 2) Suffering from life threatening trauma (i.e. bleeding to death). There is a high incidence of stomach cancer in this area;(another elder of this village died this winter of stomach cancer after making weekly visits to the Tanana clinic where she received Mylanta) it is within the realm of possibility that the symptoms might indicate a malignancy, or ulcers, or a serious and potentially life-threatening illness. Someone at the City Office volunteers to help her and makes a telephone call to the State Social Services Office to be told that Indian Health Service is considered a "prior resource" for travel. After six telephone calls to Fairbanks, Anchorage, and Juneau, special authorization is given for the lady to travel. But what of villages where there is noone to fight through the red tape for the elderly? And what of the pride of village people who have been independent and lived a subsistence lifestyle only to be forced to turn to State Welfare programs to receive basic health care?

-Dental and Eye Care in the villages is minimal and at a level that would not be tolerated by non-native populations. Visits to the village by the dentist are yearly and concentrate on the treatment of the school-age children. Older children and adults are seen only if time permits after all the school-age children have been seen. The quality of dental care available to Alaska Natives is "Drill or Pull". Basic procedures like root-canals, bridgework, and orthodonture are not available to Alaska Natives. In this age where the modern dentist has contrived a number of ways to save teeth, PHS dentists are limited to filling teeth or pulling them. Many are pulled because the people living in rural Alaska do not have access to employment and to the money required to have reconstructive or orthodondist work done. For this reason we see pretty young girls whose smiles reveal numerous gaps and we see older people who have difficulty eating their native dry fish and game meat and turn to an unhealthy diet of macaroni or rice or anything that they can swallow without a great deal of chewing.

A dangerous misconception seems to exist in the minds of the people of the "Lower 48" as a result of the Alaska Native Land Claims Act and the recent Oil Wealth of the State of Alaska. Many people seem to feel that Alaska Natives are wealthy and able to pay for their own health care. For rural village Alaskan Natives, the Land Claims Act simply added an additional level of bureaucratic interference in their lives. Most received little, if any, financial settlement. They own stock in corporations that seldom declare dividends. Tanana, in many ways, is a fortunate village. There are a few jobs here through the school, the City Office, and the three local stores. But the subsistence lifestyle that most people live is the basis for their survival; seasonal firefighting; trapping; fishing are the only sources of income. The majority of the native people in this village have no access to employment; to private insurance; even to State Welfare programs. Indian Health Service is critical to the continued well-being of the people of this area.

It seems easy for the medical professionals to rest on their laurels. It is true that health status has improved in Tanana and in other Interior Alaska villages in the past twenty years, but is it entirely coincidental that there has been a great effort during the past twenty years to improve access to health care delivery in the rural areas of Alaska? As that trend alters and administration concentrates the dollars allocated for health care in urban treatment centers at the expense of rural health care delivery we may expect to see,and are in fact seeing, that achieved level of health drop. Since the closure of the Tanana Hospital last June, we have seen four new cases of TB and the index or source of the infection has still not been determined.

We would like to urge that the Health Care Improvement Act continue and that the direction of Indian Health Service be focused on the improvement of health care in the rural areas; that special effort be made to achieve a higher level of physician contact with rural patients and that social outreach efforts be increased to insure that those who are unable or unwilling to speak for themselves have a route through the increasing red tape to reach required medical care.

Thank you for this opportunity to voice our concerns about health care for rural Alaskan Natives.

Sincerely yours,

Arland Dick

Arland [illegible] Dick, President
Tanana IRA Native Council

Senator MURKOWSKI. Our next witness is Robert Clark, Bristol Bay Area Health Corp. Welcome, Robert.

Please proceed.

STATEMENT OF ROBERT J. CLARK, EXECUTIVE DIRECTOR, BRISTOL BAY AREA HEALTH CORPORATION

Mr. CLARK. Yes. I am from Bristol Bay, which is 1 of the 12 regions that operates a 638 program. We are operating a total Indian Health Service hospital and servicing the program out of the Bristol Bay area, formerly the Kanakanek Services. Since our 638 contract we have renamed it the Bristol Bay Area Hospital, and we have had a lot of continuing dialog with Dr. Rhoades, Indian Health Service in Anchorage, as well as the congressional folks, sharing with them our problems with trying to run the facility out there. We have approximately a $4.2 million contract, and 2.5 of that is to operate the hospital.

The area that I want to speak about is mainly regarding third-party payments. As you are aware, title IV of Public Law 94-437, which is up for reenactment has allowed Indian Health Service to collect medicare, medicaid moneys under title XVIII and XIX of the Social Security Act. If that were not around, I am not sure what the effects would be regarding third-party funding.

Also as of late, you have allowed other types of third-party funding to go into effect, but you have a neat little thing that you also put into effect at the congressional level which is called an "offset." The offset greatly reduces the funding level available for our programs, not only for Bristol Bay but for Indian Health Service throughout the whole United States and Alaska, and that has some big effects. Furthermore, that is not what was fully intended in the very beginning, so Congress is changing its mind, which I guess you can do.

Senator MURKOWSKI. We are very good at that.

Mr. CLARK. But the big picture is that you are doing it again now in other areas, all other third-party fundings, and you are seeking to gain a large part of the IHS budget moneys from collections, and I think a lot of your numbers are quite unrealistic in regards to the expectations of our collections. There becomes no incentive to really collect it if it all goes back to Treasury, and a large part of it does. It's projected that some 10 million of the first amount collected from nonmedicare and nonmedicaid sources will go back to the United States Treasury, and the balance of it will go toward deficiencies in the JCAH and the medicaid-medicare areas.

Five million of the medicare-medicaid collections go back, and then we are only able to keep collections on a 50/50 basis, so for every dollar I collect I get to only keep 50 cents, whereas in a private sector you will be able to keep the whole 100 percent. The theory is currently that we now collect 100 percent of the other third-party collections, and if Congress continues to go ahead as they are proposing, perhaps I will not even be able to collect that much to continue my program.

The same erosion effects and other concerns that you have heard from some other folks and you will hear throughout the day are very much impacting us, and we put the Government on notice that we will be running out of money this summer, by August. The fiscal year is over with in September, and the only way we can operate is by collections and other types of fundings, with some carryover ability. We are very worried that Congress may not allow carryover ability, because often, as you know with the budget problems, we do not get the money until July, August and even September—last year we got money 2 days before the end of the fiscal year. If we did not have the carryover ability, there is no way we could spend that money in a fiscally economic way, and that is what we try to do.

Under 638, our people decide in conjunction with the IHS the plans that we are putting forward to provide health care for our people, to try to improve the health service throughout the area. The system is just really lacking; and this is what 437 is all about, getting the system up, getting the health status up, and we are hearing there just is not the money, and I cannot help but echo that.

But the real fear is that there seems to be a trend toward termination by gradually reducing the IHS budget, starting with these offsets, and forcing us to make it up in collections.

Just as of late the Government hospitals themselves are able to keep a small portion of collections and we are able to keep more on a different basis given the 638 contract. But, if we are not allowed the carryover ability, if tribal contractors are not allowed to keep that money, there is no way we will be able to continue with the same level of service. In fact, the level of services is going down in many cases because of that, and only with other moneys are we able to continue and/or actually expand services.

Throughout the whole process, we have been asking for waivers. We have been saying: "Okay, we are operating it. We would like to operate it as any other private, nonprofit type of facility, or for-profit type, whatever the case may be."

Senator MURKOWSKI. I must ask you to summarize your remaining remarks.

Mr. CLARK. My main concern is that in passing the law, we continue with the medicare-medicaid, and that you really look close at the collections in areas other than third-party and take into account some of the task force's remarks that have been provided by IHS, and continue to allow the tribes to use that money to further their efforts, because we do not have the funding to do it under the IHS system as was promised us.

Senator MURKOWSKI. Thank you very much Mr. Clark, I appreciate your testimony.

[The prepared statement follows:]

PREPARED STATEMENT OF ROBERT J. CLARK, EXECUTIVE DIRECTOR, BRISTOL BAY AREA HEALTH CORPORATION

On behalf of the Bristol Bay Area Health Corporation, a P.L. 93–638 Contractor of Indian Health Service (IHS) programs in the 32 villages; 40,425 square mile part of our State, we want to say we are very happy that you were able to provide an opportunity for Alaska to provide input on the proposed reauthorization of P.L. 94–437 at your 6/3/83 hearing in Anchorage. We are extremely pleased that Dr. Everett Rhoades of IHS was able to be in attendance and hear first hand our input. We only wished that a minimum of one day could have been set aside for dialogue.

We want to put into writing some further elaboration on our concerns that would be used as part of the congressional record in favor of reauthorization of P.L. 94–437.

Since there are many pages of documentation on our right to services from the Federal government and the history of what has been provided, and what was proposed is a matter of record, we will not elaborate much on that aspect. We only want to say that P.L. 94–437 made a very good attempt at identifying our needs and what funding would be needed to overcome these problems. If funded as conceived we would have been much better off than we are today—health system and health status wise. The needs as spelled out in many documents to IHS ; the Congress and other state and federal agencies are many, and take a lot of money along with changes in laws and regulations to remedy. It is our hope that Congress will see that delays to promises made only increases the costs on many avenues.

Pages upon pages of statistics show that our health status is far behind that of the rest of the U.S. population. Much needs to be done in the preventative area, an area too often not funded but paid a lot of lip service by everyone. It is far better/cheaper to keep people out of health care institutions than to care for them once in. We need funding for prevention and detection in the form of outreach education to increase our peoples awareness of the behavioral health problems (mental health and substance abuse problems are very high), accidents, sexually transmitted diseases (AIDS and herpes have not seen fit to stay out of our peoples problems on top of normal problems), oral/dental diseases otitis media/hearing loss, food and water borne problems, heart disease and hypertension, cancer, respiratory or pulmonary disease, dog bites and rabies, other animal bites, strep throat, hepatitis B, asbestos-related health problems and diabetes to name the most common problems. These can be classified in the environment, lifestyle or biology area of affect on health care. Once problems occur there needs to be a good health care system. This is currently a deficiency area too, as we in the IHS, Native health care sector are stuck with 19th century tools in a 21st century technology state of the art for most other hospitals. We need to catch up in order to keep abreast with what's happening. This means computerizing, building new facilities that meet codes and are cost effective and more efficient to run while meeting today's style of health care practice. It is not cost effective or even reasonable to practice today's medicine in a wooden hospital such as the one we operate at Kanakanak built in 1941 to meet the "T.B." long term care recuperation type problems when today we are more outpatient intensive for other types of problems. The ridiculousness of this is in the totally inadequate army metal quonset hut (that leaks when it rains) used for all outpatient functions attached to our 29 bed inpatient facility. The technology to speed up work, save space, collect third party revenue is all around us, but currently not available. The folks we need to help run our system are being trained in a setting very different than what we have to offer. The fifteen requirements of a well functioning Emergency Medical Services System under P.L. 93–154 are lacking. Not because the technology isn't there or the need or desire isn't there, but because the money from Congress to upgrade us to the 21st century isn't there. We would at the same time concede that money isn't everything, but it is far easier to maintain a new or more efficient system than an old unefficient one designed for another time and need.

It is our desire that Congress appropriate the necessary funding to build our planned for replacemet facility scheduled to be built the summer of F.Y. '84 if the funding is there. We hope, too, that the Planning Information Document (PID) for our needed 25 units of housing and additional necessary staff are approved at the same time.

Due to the remoteness and the high turn over of staffing, we urge Congress to provide adequate funding for any Indian/Alaskan Native that desires to pursue education in a health or related career be fully funded via a scholarship. We need our own people involved. We need the sensitivity that only our people can have by growing up here to be used to help our people by going out to get an education and coming back home to apply these skills.

We need secure and adequate funding for our community health aides (chas) and community health representatives (chr's). They need a salary level to properly compensate them for their "first line" provider job status, they need proper protection to be able to serve everyone in the village, they need adequate training and certification/preceptorships set up, IHS and the State needs to coordinate the clarification of the cha's role and provide proper back up and support so that this becomes both a State and IHS responsibility. The large number of environmental health problems points to the need for P.L. 86–121 funding to be reestablished. It should not be tried only to new HUD or BIA housing projects so that proper flexibility to meet needs can be accomplished.

It should be stressed to all funding sources, i.e. National Health Service Corps., Rural Clinic funding, etc. that contracts with our regional health corporations should be encouraged, furthermore, that we service all people in rural Alaska based on particular funding constraints. We do not exclusively serve natives as some may imply. Due to the small population base in a large area, we will continue to need subsidization on our operations. Third party funds help, but there is only so much to be collected. Also, if Congress doesn't let us collect and keep 100 percent of the collections, we need some way to make up for offsets not funded by Congress in Medicare/Medicaid and as proposed for all other collections. At the least the P.L. 93-638 contractors should be exempt. Where is the incentive if we see continued reductions to IHS budget and our contract which is tied to IHS funding levels? Isn't this the first step to termination? How do we go about encouraging our people to pay when by doing so we get reduced accordingly? Why encourage our people to buy health insurance or group insurance policies if in doing so they see an eroding of services due to a corresponding decrease in our base funding? The insurance should be supplemental funding to increase services, make our limited dollar do more. Congress, OMB and others must very clearly look at what is being said by the tribes and IHS in this area.

When P.L. 94-437 was first passed it was never intended that Medicare/Medicaid collections be offset. This penalty was deemed to be illegal by Congress and IHS and the tribes and we felt it was not to be imposed beyond the first time after this was pointed out.

More flexibility with the budget IHS receives should be allowed, however, not such that it prevents P.L. 93-638 contracts or imposes an undue hardship on Tribal contractors. This should be an area agreed to by Tribal contractors and not be top down imposed. Perhaps to get this, Congress needs to consider raising IHS to a level comparable with BIA. Existing relationships within IHS should remain in a modified form, however, as we have come to rely on the structure as is.

An acceleration needs to be put into effect on IHS' plan to serve non-natives in IHS facilities. The information begun in September of 1982 todate between Bethel, IHS, Senator Stevens, Dr. Rhoades, Dr. Robert Graham, et al., all has seemed to have stopped. We continue to urge Congress to allow Indian/Alaska Native ownership of IHS facilities via P.L. 93-638 as well as leasing of facilities and recommend more research be put to those areas as requested in the "Significant reports required of IHS to provide to the Senate/House Conference Appropriations committees as referenced in the F.Y. 1984. Volume VI, Justification of Appropriations Estimates for Committee on Appropriations, Indian Health." We do not agree with IHS or Congress in their recommendations. Our letter of March 22, 1983 to Senator Stevens spells out our thoughts on this. (attached)

Our running dialogue of letters sent to Congress and IHS by our corporate P.L. 93-638 attorney, S. Bobo Dean, should all be considered for the record as improvements to the system, the regulations, and laws. Without his efforts, we would not be able to exercise all our options even though they are there to be exercised, if allowed to do so.

We request that Congress allow IHS the ability to waive OMB Circulars for tribes under P.L. 93-638 contracts that make sense to do so from IHS and the tribes view points. A case in point, OMB-A 45 locks us into rental rates that are not fully recovering costs, and are 50+ percent below the private sector comparable rates. We cannot currently, without a waiver, adjust up to private sector rates, even though that was the intent of the circular in the first place.

We have to seek IHS' prior permission to buy equipment $200.00 or more and on all "sensitive items" no matter the cost. This is a very cumbersome and time consuming task. We request that IHS be given the ability to waive this contract provision for BBAHC's contract. Another option may be to raise the $200.00 limit to $1000.00.

The Alaska Cost Consideration Study done by IHS for Alaska should be funded as per our equitable needs based on the higher cost of doing business in Alaska. Alaska's loss of buying power between 1973 and 1983 has been estimated in excess of $21 million (drop from 19% to 16% of the IHS overall budget). Several considerations spelled out are key to providing good health care in Alaska.

It is very crucial to our contracting process that Congress allow carryover ability at the tribal contracting level. By the time Congress passes the budget and it goes through the process of getting to us, over half the year is gone. Last year BBAHC did not know till September what we had for the fiscal year. It is important to have the appropriate wording aded to the appropriations language for this.

We urge Congress not to take immediate action as it had in December regarding the provision of care to non-beneficiaries married to beneficiaries. We request a transition time for such actions to go out in the proposed rule making process with hearings and time for input. There were several recommendations provided to IHS by its Task Forces that were proposing several real controversial measures in this area.

Decentralizing IHS to the extent feasible while still maintaining a streamlined "system" is very important. The numerous articles on health care in the many health magazines all speak to the problems of free standing facilities not being able to make it on their own, so a systems approach does have a lot of merits if designed properly. The IHS system in theory has all the main components if one takes into account the tribal contractors, but it must be revamped to meet todays style of health care. The level of care approach emphasized by the Health Systems Agencies (P.L. 94-641) is essential as care goes from the village, subregional, regional and statewide levels. Economies of scale and centralization must be tempered with decentralization functions, not always easy but important to our self-determination efforts.

In closing, we strongly urge Congress commitment to reauthorization of P.L. 94-437 at the fully conceived funding levels along with proper funding of IHS and P.L. 93-638 contractors requests.

We remain available to provide more elaboration where or when necessary.

I am available at the Bristol Bay Area hospital. Please feel free to call anytime for further information.

Senator Murkowski. Niles Cesar, executive director of Southeast Alaska Regional Health Corporation?

Ms. Peters. Niles could not be here. He is in Fairbanks and I am Clara "Billie" Peters.

Senator Murkowski. Are you going to read his testimony?

Ms. Peters. Yes.

Senator Murkowski. We appreciate your doing that. Please, proceed.

STATEMENT OF NILES CESAR, EXECUTIVE DIRECTOR, SOUTHEAST ALASKA REGIONAL HEALTH CORP. AS READ BY CLARA "BILLIE" PETERS

Ms. Peters [reading]. Public Law 93-638 allows for assumption by tribes and tribal organizations of functions which have historically been provided by the Federal Government. With the passage of this act, tribal organizations in Alaska began to aggressively pursue self-determination contracts.

While many tribes in the lower 48 States view Pub. L. 93-638 with a great deal of apprehension, we in Alaska embrace, if not the myriad regulations, certainly the spirit and intent of the law.

Since 1975, a great many health programs that were originally provided by Indian Health Service are currently under contract to the 12 regional health entities spread throughout the State of Alaska.

Because of the differing natures and locations of the regional corporations, their differing administrative structures and complexities, we all have an administrative cost factor—indirect rate—which is different for each organization.

Just as there is a cost associated with tribal management of programs, surely there is an administrative cost to the Indian Health Service management programs. Theoretically, as tribal organizations assume management, there is a corresponding decrease in administrative costs to the Indian Health Service. Practically speaking, the opposite has in fact been the norm. We as contractors find we are burdened with excessive review by IHS administration to provide an avenue for their administrative talents as direct program responsibilities have eroded.

Moneys which tribal organizations should receive to administer IHS contracts oftentimes are retained in large measure to fund these IHS overseers. To compensate the tribes for this inequity, and recognizing that IHS has been unable to provide either the precise percentage figure which represents the administrative cost rate, the indirect costs, or a rationale for its development, supplemental and direct monies have been provided to most organizations erratically.

Each tribal contractor has a federally negotiated indirect rate which describes the cost of doing business. There are many types of indirect rates, but the three most familiar to contractors are onsite, offsite and flowthrough. Each rate is calculated based upon the premise that administrative functions are shared between programs and costs are allocated equally between. Some programs are handled from a central office onsite, and some from a field office onsite, and some, mainly administrative and accounting in nature, flow through

Just as there are types of indirect rates, there are ways of calculating the rate itself on salaries and wages, on total direct dollars, to breaking down specific jobs at cost to each program and charging the individual program directly.

Obviously it is a confusing situation, but one we must as contractors continue to grapple with. The bottom line for tribal contractors is the fact that there are administrative costs incurred that must be both recognized and funded. Direct program dollars are limited and cannot be expected to furnish indirect dollars with which to fund administration.

The Federal Government, in the guise of Indian Health Service, must provide those indirect funds to contractors if Indian self-determination is to have any meaning at all. We see this not as a request but rather as a demand that the spirit and intent of the law be adhered to.

In earlier years, the Alaska Indian Health Service doled out indirect support dollars based upon no specific criteria, but rather on the "squeaky wheel premise". This approach has caused severe shortfalls for some corporations, and in some areas inappropriate over-allocations. Contractors have repeatedly pressured the Alaska IHS Area Office for equitable distribution, without avail.

We request that the issue of indirect support to tribal contractors be given high priority and IHS be directed to realistically determine what the indirect rate is for each of the programs it administers.

I thank you for the opportunity of sharing this testimony with Dr. Rhoades, and with Senator Murkowski.

Senator MURKOWSKI. Thank you very much, Ms. Peters. We appreciate that testimony and it will be noted that it was given by you on behalf of Niles Cesar.

Several of the questions that we had for the panel have been answered and I don't want to be repetitive. I am curious to know, in your judgment, if you have had any situations where there has been a question of a near-miss on whether to fly or not fly a patient based on the availability of travel funds? Have you had a crisis or have you had enough flexibility so that you could actually respond, based on what was in the patient's best interest.

Mr. **Mather.** I think the lack of travel funds does not show up in emergency situations. Normally, the travel funds that remain are prioritized. The people that are damaged by the lack of travel funds are the older patients who have very little resources and have chronic conditions that require routine maintenance, and because those funds are not available they do not get the routine maintenance and then they frequently break down and have acute problems. I am sure the people that are most damaged would probably be the older individuals in the population.

Ms. **Patkotak.** It should also be noted that prior to this time, pregnant women had been encouraged to come into Anchorage to deliver in a hospital setting. It creates dependency that you deliver in a hospital in a safe setting. Now with travel funds cut, the funding is not there to bring them in a month ahead of time, and frequently they are staying there in the villages and having their babies because they do not have the funds to come in and stay in a town a month ahead of time. At the same time, we no longer have the expertise in our villages to provide for deliveries because the midwifery skills went downhill when the encouragement toward hospital-based deliveries was being pushed by IHS previously.

Senator **Murkowski.** So you are caught in a dilemma.

Ms. **Patkotak.** So now we have a dilemma where the women cannot come in to get the care that used to be given.

Senator **Murkowski.** I have one last question. This question was suggested to be directed to the Alaska Federation of Natives' representative, but I think you people who are responsible, as regional health directors, may have a different, perhaps more objective response: I am curious to know, since the last panel identified the major health problem as being alcohol and drug abuse, what is your opinion of the prospects for resolving the problem?

What is your forecast for the alcohol and drug abuse problem in rural Alaska if not arrested? Do you see it moving—those of you who have had an opportunity to view it over a period of time—moving rapidly in one direction or the other? I realize it is a difficult question because a lot depends on your perception and how long you have been observing it, but I would appreciate any comments that you care to make. I think it is valuable for the record.

Mr. **Mather.** I think there has been a realization over the past 3 years by the Native community that this is the most preventable and serious problem facing the Native community and must be addressed.

Senator **Murkowski.** I know that, but I want to know what is happening. Is it getting worse or better?

Mr. **Mather.** Because of this realization, I think it is getting better. There are numerous villages that have exercised their local option and have voted to go dry. I think that is a tangible result. It is recognized that everyone is struggling with the appropriate intervention and methodology and, you know, what works in this field is by no means certain, but I think there have been dramatic improvements, especially where there are communities taking care of the problems themselves.

Senator MURKOWSKI. Do you generally agree? Anyone else—Ms. Peters?

Ms. PETERS. Yes. We, within the past 2 years, have instituted our own regional alcohol treatment center which is a 4-week to 6-week facility, 24 hours a day, and I can really say we have seen some positive things come out of that.

Senator MURKOWSKI. Good, and I appreciate that. Are you using whatever funds you can beg, borrow or whatever to do it?

Ms. PETERS. I would have to say it is coming out of equity, our equity funding has chiefly supported it because it is our No. 1 health need. And we also have asked the State recently for some more funding so that we can keep it open 24 hours a day; otherwise we will go to 8.

Senator MURKOWSKI. Any other comments?

Mr. CLARK. We used to train local people in the villages as Alcohol Counselor I's, certified under the State, using CHR funding. We did that, but the precariousness of the funding each year forced us to lose a lot of those people and they have taken other jobs and are not doing alcohol counseling. We have that on a local level and a State program, the "Here's Looking At You" program. This is a value clarifications-type program through the school with a concerted effort by the counselor saying, "It's just too much of a problem; we're going to have to vote the village dry." Our local program tries to bring in that awareness of alcoholism as a health issue, but it still needs a certain profusion of money to make it go. They built a nice little building but there is no more funding to keep it going so it just starts to fall into some state of disrepair.

Senator MURKOWSKI. Mr. Clark, is it reasonable to assume that there are some contributions being made by those that are motivated by religious organizations in the villages that are trying to assist in the rehabilitation effort? Also, is there any contribution from the private sector to assist in rehabilitation? The liquor industry has tried to some extent to make funds available for educational purposes. I have no idea how that is working.

Mr. CLARK. There is very little in my area. It is one of the richer areas in the State because of fishing and all that, but there just is not that particular type of interest so that if you did not have a core group of staff that are funded either by Federal- or State-type programs, there is not a lot of incentive for other folks to keep it going. We have gotten so accustomed to having somebody else doing it that it is hard for us to have that community volunteerism spirit and everything, though it is coming back to some degree. However, it is not like it might be in some other places, unfortunately.

Senator MURKOWSKI. Thank you for your response. Yes, go ahead Elise.

Mr. PATKOTAK. There is a real danger here with so many villages now going dry under a new State law that gives them local options. The feeling there is that alcohol and drugs are bad, but what you have got is a whole group, especially in your smaller villages, of people who routinely abuse and/or use drugs and alcohol. In the smaller villages, those people are starting to be alienated because they are no longer accepted, whereas for years that behavior had been tolerated. Unless you have the money to train them and get some people into the villages to deal with the problem, drug abuse or alcoholic, you have the danger of them becoming alienated from their community, and they are eventually going to leave and they are going to end up in the urban areas. You are going to see an increase of the Fourth Avenue population because they are now being alienated from the one place that they could stay and be tolerated and somewhat supported in the past.

It is kind of good that the communities are aware of it, but it is bad that they do not know what to do with the people they can no longer accept within their community.

Senator **Murkowski**. Thank you. I want to thank the panel.

Did you have a comment?

Mr. **Del Rosario**. Just one comment, Senator. I just hope that, you know, with all this attention being focused on alcoholism that it is not going to be a fad or anything like that, where people start saying: "Okay, let us start putting all of the money on alcoholics," and then we forget that there is still a lot of need in primary health care, for instance, especially out in the villages for our community health aides and community health representatives. You know, all of these Dillingham-based primary health care practitioners might find themselves out of the budget.

Senator **Murkowski**. Your point is well made. I appreciate that.

Mr. **Del Rosario**. Thank you.

Senator **Murkowski**. I want to thank the panel of regional health directors, for their testimony and go on with panel three, village representatives. My list shows that we are going to have Tina Gray; Eleanor McMillan, Doreen O'Dell, Esther Curtis, Clara Morgan, Ethel Lund, and Frank Peterson.

Would you introduce yourself and please proceed. I am going to remind you that I am going to hold to the 5-minute time limit.

Ms. **Gray**. I am Tina Gray.

Senator **Murkowski**. Tina Gray. It is nice to have you with us.

STATEMENT OF TINA GRAY, VILLAGE HEALTH REPRESENTATIVE, AKUTAN ISLAND, ALASKA

Ms. **Gray**. I am the only health care provider out in Akutan, which is on the Aleutian Chain. The population of Akutan right now is about 76. That is, the people who are natives to the town.

Senator **Murkowski**. Seventy-six, and Akutan is how far from Anchorage?

Ms. **Gray**. It is between 700 and 800 miles.

Senator **Murkowski**. What is the cost of a ticket, from Anchorage to Akutan, roughly?

Ms. **Gray**. Round trip you are looking at between seven and eight hundred dollars.

The people cannot afford that. Fishing is down. If they have a problem in Anchorage, they call Anchorage and the doctors say they should come into town. The hospital would not provide the money, the transportation for them, so they are expecting—they are sitting out there, and cannot come in, and they do not have the money—they are expecting me to be a miracle worker. I cannot do that.

For the transportation costs, trying to get an emergency med-evac out of Akutan—I do not have an airport there. If it is blowing, the surf is up, the seaplane is not going to land, so the patient sits there from between—I have gone 48 hours without being able to get a plane in there to get a person out.

Senator **MURKOWSKI**. Could you call a Coast Guard helicopter?

Ms. **GRAY**. Not when the weather is bad. They are not going to come in. They are not going to risk their lives—I am not going to risk mine for putting what, between two, three, four other lives in danger trying to get one person out of there.

Being the only person in town and working 24 hours a day, 7 days a week runs you down and you just do not have the money to go and train another person to take my place while I am out of town. So, actually, right now, there is no one in the Bay providing any professional medical care to the population.

And the population right now for the entire bay is sitting at about 200 people. When the fishing season is good the population of Akutan is about 2,000, and I am the only person. We need some more money from somewhere to help improve the medical care that the people do get out there, and the help to get the people in to town when they do need to see a doctor.

Senator **MURKOWSKI**. You made your point very well, Tina. We appreciate your testimony.

Is Eleanor McMillan here? Eleanor, we look forward to your testimony. Please proceed.

STATEMENT OF ELEANOR McMILLAN, PRIMARY HEALTH AIDE, PORT GRAHAM, ALASKA

Ms. **McMILLAN**. Thank you, Senator. I am from village a little bit bigger than where this lady is. I am the primary health aide.

The village averages about 160 people during the winter months, and increases by a hundred during the summer months when the fishing season is in operation.

Senator **MURKOWSKI**. What village?

Ms. **McMILLAN**. Port Graham, down across from Homer. The paradise of Alaska.

I serve on very many committees in my community. I wanted to let you know about these things, not because I feel like I have to but because there are concerns and needs in the community. I serve on the Village Council, the Village Health Committee, the Area Mental Health, Area Alcoholism Board and the church committee and Health Aide Association of the State. I have had training; I have completed all three phases of my health aide training here in Alaska and the community health aide program branch here in Anchorage, which I thought was very good. I was one of the fortunate people, and was able to complete it in a 1-year process.

I have worked in my village as a health aide from the year 1972. I did not always get paid for that until a year ago. I was placed on full time as a full-time health aide.

The location of my community, I said, was across from Homer. Very pretty: lots of mountains, lots of rain, lots of wind.

Senator **MURKOWSKI**. Lots of fish?

Ms. McMillan. Sometimes. Right now it is.

OK, we have transportation into the community either by boat or by plane, and again, like this lady here, when the weather is bad there is no transportation, either by boat or plane. Sometimes it is very difficult to have a patient transported just across to Homer.

We have a hospital in Homer, contract services—not with the hospital anymore. Those have been discontinued, but with doctors in Homer and Seldovia.

Senator Murkowski. Will the Coast Guard bring the buoy tender over from Homer on occasion?

Ms. McMillan. Yes, you can expect that Coast Guard aircraft or boat to come in within—from the first time you call them, 2 or 10 hours later; lots of communication, lots of problems.

I can understand their problems, too.

Public Health Service provides support systems. I consider Public Health Service a support system for me. The State has cut their budget, or has not increased their budget, so as a result the Public Health nurse is in my village, on the average of every other month or every 3 months, according to her budget. We have contract services with the doctors in Seldovia and Homer, a dental contract for dentists coming into the village twice a year.

Those contract dollars with the doctor in Homer or in Seldovia, I can expect to send a patient in maybe the first 6 days of the month and plan on them having their expenses paid. Other than that, the dollars are all used up, there are no more dollars, and as a result patients end up with large bills.

Senator Murkowski. I would ask that you summarize your remaining remarks.

Ms. McMillan. I have a big concern for the health problems I have had in my community. The rate of cancer this past year: I have had four people die in my community. We have four people now suffering from cancer in our community. Those are dollars—you're speaking of dollars, hospitalizations and health care for those people.

Cardiac: Lots of heart patients with heart problems. Those people require lots of dollars.

Alcohol abuse: I consider and say that easily 80 to 90 percent of the injuries, the health problems I have with my people in the community are alcohol-related. We do have alcohol counselors, but it is a very difficult problem to deal with.

Senator Murkowski. Thank you for identifying those important problems.

Our next witness will be Doreen O'Dell.

Doreen, we welcome you to the hearing and we look forward to your testimony. Please proceed.

STATEMENT OF DOREEN O'DELL, COMMUNITY HEALTH REPRESENTATIVE, BARROW, ALASKA

Ms. O'Dell. I am Doreen O'Dell. I am a community health representative for Barrow here in Anchorage, and I have one worker over at ANC, an outreach worker, an Inupiat interpreter for our patients that come in from our North Slope area. What I am concerned about is when IHS sends patients out from our area, they send them down here telling them that they have a place to stay. By the time they get here they do not even have a place to stay.

Senator MURKOWSKI. They cannot go in the hospital.

Ms. O'DELL. Well, the hospital tells them that, but by the time they get here something comes up and they have no place to stay. Most of our patients that do come from our Slope area are cancer patients and it is pretty hard to try and find housing and stuff like that for them in a short period of time. They are also critical patients.

Senator MURKOWSKI. And the hospital?

Ms. O'DELL. They are booked most of the time.

Senator MURKOWSKI. ANS Hospital does not provide any place for them?

Ms. O'DELL. Well, they do, but sometimes, you know, they are booked themselves.

Senator MURKOWSKI. What do you suggest?

Ms. O'DELL. I think they should be more conscious of who they tell that they or we can provide houses or quarters or a hospital. We should double check it more because many of our patients come here on a one way ticket and they have no place to stay, and most of our patients that come here are elderly patients. Sometimes we have to take them in our own house. You know, that is no problem because they are our people and we have to provide help for them, but IHS has to come up with a better offer. I am not saying IHS is all that bad, for they do good work, but they also have to come up with a better offer.

Senator MURKOWSKI. I understand.

Thank you very much for those observations, Ms. O'Dell.

Esther Curtis?

Ms. CURTIS. Thank you, Senator Murkowski.

Senator MURKOWSKI. We welcome you to the hearing. We ask that you speak into the microphone, please. We want to get all of your testimony.

STATEMENT OF ESTHER CURTIS, COMMUNITY HEALTH REPRESENTATIVE, NANA REGION, ALASKA

Ms. CURTIS. Thank you, yes.

I am honored to attend this important IHS hearing. Dr. Rhoades, I want you to know that I am a friend of the doctors. I have worked with them since I was 18 years old under Dr. E. S. Rabeau. He was a doctor at the Kotzebue Hospital, and I worked with him for 9½ years. I am proud to see every one of you way up in the top.

Senator MURKOWSKI. Thank you. I speak for Dr. Rhoades.

Ms. CURTIS. I know that I have someone at the top to back the community health aide program.

I represent the community health aides in the NANA Region, where there are 11 villages. The smallest village averages 60 people, and the bigger villages average 500 people. We have community health aides in the smaller villages and two in the bigger villages. All of these total 15 primary health aides in the 11 villages and they are paid from IHS/Washington.

Primary health care providers in the villages have proven their effectiveness over the years. TB has decreased in our area, and infant mortality has decreased. When I first started working as a local health aide at Kiana, we did not have any sanitation or water and sewer. The mortality rate was high with diarrhea and meningitis, and that has decreased.

The health aides right now take care of episodic care, everyday problems, emergency care, preventive care and sexually transmitted disease programs. They are the main people that all offices come to when they go to the villages from different health programs.

Training is necessary for the community health aide program. They are certified and they need continuing education annually, and alternate training also is essential now because of our older primary health aides. They have worked from 10 to 20 years, the older ones, and they are thinking of retiring now, so we really need to train other alternates in the villages.

We all know that life is more valuable than money. If we did not have health, none of us would be here. I was in the hospital Sunday, this last Sunday, with a real bad nosebleed, and I was in the hospital for 4 days, and if it was not for Indian Health Service I would not be here. So lots of times, thinking of community health aides in the small villages, they are the main people that give medical care. And if any one of you went to our small villages and happened to have a real bad heart attack, they are the ones who you would go to in a small village, and they would take care of you. Dr. Rhoades would have to tell them what to do, but they would do it for you.

They would start an I.V. and they would do the essentials under supervision.

Senator MURKOWSKI. Thank you, very much.

Ms. CURTIS. I still have a little more.

Senator MURKOWSKI. OK.

Ms. CURTIS. I would like to use the respiratory system as a sample of a vital sign that is needed for every one of us.

The bronchi represent the IHS, and that is the main respiratory tract. I mean, you are the top people in Washington, D.C. The bronchioles represents the Alaska Medical Center, including the CHAP program in Alaska. That is also needed, but that is smaller, below IHS.

And the alveoli represent the community health aides. That is where the oxygen and the carbon dioxide exchange.

So the community health aides are really essential in the smaller villages. If they are not there, most of us would be mucky.

The Alaska Natives, our fathers, our grandfathers used to say "mucky" when they meant "die."

So, we really need your support, and tell President Reagan for us, please, that IHS is really essential for Alaska.

Thank you very much.

Senator MURKOWSKI. Thank you, very much, Ms. Curtis, for your very graphic description; a lesson in body chemistry. I was never too good in chemistry. Obviously Dr. Rhoades is the expert in that field.

As you have pointed out, he would be happy to tell you what to do, and it is reassuring to know that you will go ahead and do it.

Ms. CURTIS. I plan to do it. I do not intend to retire.

Senator MURKOWSKI. That is good. We do not want you to retire; you are too effective and doing too fine a job, and we thank you. We thank you for your spirit of cooperation, and particularly your pointed contribution, and we will take your message to the President. I do not know if I am going to be able to explain to him what "mucky" means, but I will try.

Ms. CURTIS. I want you to know that I helped put you in office also, Senator Murkowski.

Senator MURKOWSKI. I thank you. I appreciate your confidence and hope to continue to have it, and if you have any influence over your friends, I would appreciate that, too.

Clara Morgan?

Mr. CHARLES. Senator Murkowski, I am Frank Charles and I will be sitting in for Clara Morgan.

Senator MURKOWSKI. Fine, Mr. Charles, please proceed.

You are from where, Frank?

STATEMENT OF FRANK L. CHARLES, HEALTH EDUCATION ASSISTANT, YUKON KUSKOKWIM HEALTH CORP., BETHEL, ALASKA

Mr. CHARLES. I am from Bethel.

Good morning, Senator Murkowski and the distinguished members of this panel. I thank you for the opportunity to appear before you today.

As I said, I am from Bethel, Alaska, which is in southwestern Alaska. I am a full-blooded Yupik Eskimo and a lifetime resident of southwestern Alaska. I presently work for the Yukon-Kuskokwim Health Corp. as an assistant health educator, and I am currently the coordinator for the hepatitis B community information program. However, I am testifying today as a consumer of health care in our region.

I believe I can speak for many people from my area and throughout the State of Alaska. It is a well-documented fact that southwestern Alaska has been recognized to have the worst socioeconomic conditions and the worst health problems in the United States. The present health care delivery system in our region has done little to alleviate this. At best it has kept the situation at bay, keeping it from becoming as bad or worse than any poor Third World country in the world. I am not putting the blame on the present health care delivery system, but rather on the lack of funding to keep the system operating at a minimal level.

At present, the health-care delivery system leaves a lot to be desired. This has created the feeling among many people that the obligation that the U.S. Government has taken upon itself has not yet begun to meet the aim of quality health care for all.

I see the termination or reduction in funding for health care delivery services as a direct threat to my people. As it stands now, nine out of ten people in my region could not even pay for the simplest of treatments, much less pay for the transportation necessary to reach the only hospital in southwest Alaska. The importance of keeping, or even increasing the level of funding for health care delivery cannot be measured. What can be measured will be the cost of cultural pride lost.

For what peoples can maintain a spirit of commonality and pride of their own self-worth when they suffer at the hands of others' insensitiveness and uncaring?

I can point out many instances of neglect and poor service because of limited manpower and services. My mother at one time had a ruptured appendix. This was only discovered by a fluke. It was not until she was seen by three physicians that it was discovered that the appendix had ruptured, even at the first visit. It was told to her later that she barely escaped death from this happening. All the people who saw her could only say that they were sorry.

My grandmother has been the victim of drug overdoses following the care of health care providers, only because the services provided to her were minimal. If a competent doctor or nurse were assigned to her, this probably would not have happened.

My own children have suffered at the expense of their health because of poor service. When they were first diagnosed as having severe otitis media, they were given an ineffective medicine. The doctor who saw them did not apparently know the proper protocol involved with children who have otitis media. Otitis media is the suffering of many Alaska Natives.

Many of my friends and relatives have had similar experiences. Yet these same people still go back. Why? Because of the simple fact that there is no alternative. Even if there were, it would be out of the reach of many people who would not be able to afford it.

The Alaska Native, as you may be aware, is in a great state of flux. There are many currents of change constantly eroding our peoples culture and pride. Each in their own way has been, to say the least, a powerful influence on the way we live today.

We are relatively new to the western way of life. My own father, for the most part, lived the life of a true Yupik. His father before him, and their fathers, lived completely off the land. I myself do so when I can. We are still learning to cope with this society.

The present health care delivery system is an important aspect to the lives of our people. Without it we would not even begin to make the small strides we have done to date. I urge you strongly to keep in mind the Alaska Native needs time, and much of it, to bring himself to par with the white man's way of life. A reduction or termination of funding in even one aspect of our lives will severely threaten our existence as Alaska Natives. Therefore, I urge you not to consider a reduction or termination in funding, but rather to continue or even increase the level of funding for health care delivery services. The delicate web that has been woven cannot be severed as we the Alaska Native will suffer.

Senator MURKOWSKI. Thank you very much for the fine testimony, Mr. Charles.

Frank Peterson, we welcome you to the witness table and look forward to your contribution.

STATEMENT OF FRANK PETERSON, PRESIDENT, LARSEN BAY TRIBAL COUNCIL, LARSEN BAY, ALASKA

Mr. PETERSON. Thank you.

Senator Murkowski, Dr. Rhoades, my name is Frank Peterson and I am President of the Larsen Bay Tribal Council. I am a director of the regional tribal organization, the Kodiak Area Native Association, and I am also a member of the Alaska Committee to the U.S. Commission on Civil Rights.

I would like to submit for the record the response to a letter from Senator Mark Andrews. I would like to submit for the record the minutes of our tribal council meeting. I would like to submit for the record a copy of our constitution and bylaws. I would like to submit for the record a news article dated February 21, 1982 and a letter from Dr. Jorgensen of Finland.

Senator MURKOWSKI. The appropriate items will be submitted for the record.

I would ask, for the benefit of the court reporter and the others in the room, that you speak a little louder, into the microphone, and please proceed, Mr. Peterson.

Mr. PETERSON. Thank you. I will read the letter and minutes.

Hon. MARK ANDREWS,
Chairman; Select Committee on Indian Affairs.

DEAR SENATOR ANDREWS: Thank you for your letter dated May 19, 1983.

We received it on May 25, 1983. Our Tribal Government convened a special meeting on May 27, 1983 to consider the letter and has authorized the submission of written and oral testimony to this committee. We will submit our written testimony within 30 days from this date following our regularly scheduled June meeting.

Sincerely yours,

FRANK PETERSON.

The minutes of our meeting where the letter was considered is the following:

SPECIAL MEETING, MAY 27, 1983

Meeting called to order at 10:35 a.m. by President Frank Peterson. Present: Frank Peterson, Frank Carlson, Marlene Aga and Alex Panamaroff. Absent: August Aga, Dora Aga and Charles Christensen. Quorum established.

Letter regarding hearing on health to be held June 3, 1983. Frank Carlson stated he would like funds for the road to our dump. Is health problem where it is.

Frank Peterson stated we have approval to appear at the hearing. Frank Peterson feels the elevation IHS Director to Assistant Secretary would be a good thing. Marlene brought up the problem of having to wait such a long time for medication. Frank Carlson stated that we have gotten equipment only by finding the funds ourselves. The clinic is being outgrown. Why can't we have an x-ray to save air fare and cost of leaving village? We need funds to upgrade our clinic. Frank Carlson stated that he has a letter from the Head Surgeon of a Denmark Hospital. Dr. Jorgensen stated he has a lot of young doctors that would like to set up a program where they would supply us with a doctor yearly. These doctors would stay one year at a time. For this, we need additional funding for planning, medical facility, and medical team. We could combine Larsen Bay and Karluk. We have an Air Service stationed at Larsen Bay that makes it very feasible to incorporate the two villages.

In the summer, four and a half to five months, our population increases to approximately 800 people. We have approximately 65 students K–12, and 12 preschoolers in our village.

We would like to support the reauthorization.

Our health program has greatly improved over the last few years. However, we want to continue the increase, not stand still. We support the CHA and CHR programs; however, we feel that if we could have a doctor here the upgrade would be a great benefit along with the CHA and CHR.

We need to upgrade our clinic facility, supplies, equipment and personnel.

638: We have not been provided the opportunity to give input into the development of the existing health contract for Larsen Bay.

Cuts in Budget: When there have been cuts in the programs, the first place to be cut has been in the villages. We do not like to see cuts. However, if there must be cuts then it should be shared equally with the program administration.

We need to increase funding for the preventive health field. The program "Here's Looking at You" is a good program only if it continues year after year, and we would like to promote this program for alcohol and drug abuse.

We feel the patient should have their choice of doctors without fear of denial of their medical rights. All the doctors in the Kodiak area should be contracted on a use basis.

Water and Sanitation: This is a continuing problem, and it does need to be improved and rectified.

We have no copy of the IHS recommendation on contract health care services. We cannot respond except as stated previously.

We do support the continued contract with hospitals, as we cannot justify a 10-bed hospital here at this time.

Marlene Aga moved to send Frank Peterson, President, to the hearing to give written and oral testimony as discussed.

The rest is the motions on the meeting.

I thank you very much for this opportunity on behalf of the Tribal Council and the Native Village of Larsen Bay.

[The material submitted by Mr. Peterson follows:]

TRIBAL CONSTITUTION
OF
THE NATIVE VILLAGE OF
LARSEN BAY, ALASKA

PREAMBLE

WE, THE PEOPLE OF THE NATIVE VILLAGE OF LARSEN BAY, ALASKA, HAVING A COMMON BOND AND RESIDENCE, IN ORDER THAT WE CAN ACT AS A GROUP, AND EXPRESS OUR WILL AS ONE; TO PROMOTE OUR WELFARE, OPPORTUNITY, ENTERPRISE AND DIGNITY, WE ARE BINDING OURSELVES TOGETHER UNDER THIS FORM OF GOVERNMENT, IN PURSUIT OF SELF-SUFFICIENCY, SELF-DETERMINATION, HAPPINESS AND OUR OWN DESTINY IN THIS SOCIETY. WE WILL DELEGATE SOME OF OUR INDIVIDUAL POWERS TO A GROUP OF LEADERS, AND THOSE ELECTED OR APPOINTIVE LEADERS, WILL ACT FOR US. WE WILL RESPECT THEIR DECISIONS AND LAWS BECAUSE THEY ARE OUR REPRESENTATIVES--BUT ONLY AS LONG AS THEY ABIDE BY THESE RULES AND PROCEDURES WE HEREBY SET OUT.

THEREFORE, WE THE PEOPLE OF THE NATIVE VILLAGE OF LAREN BAY, IN ORDER TO BUILD OUR ORGANIZATION AS A TRIBAL ENTITY ACCORDING TO ESTABLISHED TRADITIONS; TO FORM AN ORDERLY REPRESENTATIVE GOVERNMENT, TO PROMOTE THE WELFARE OF GROUP MEMBERS AND THEIR CHILDREN; TO EXERCISE CERTAIN RIGHTS OF HOME RULE; TO SECURE THE BLESSINGS OF FREEDOM AND LIBERTY; TO DEVELOP NATIVE RESOURCES; TO CONSERVE THE TRIBAL TERRITORY; AND TO PROVIDE A WAY OF ORGANIZING TO DEAL WITH ELEMENTS AND ENVIRONMENT OF THIS SOCIETY, DO HEREBY ESTABLISH THIS CONSTITUTION AND BY-LAWS.

CONSTITUTION

ARTICLE I - NAME

THE NAME OF THIS ORGANIZATION SHALL BE THE NATIVE VILLAGE OF LARSEN BAY.

ARTICLE II - DEFINITION OF TERRITORY

THE BOUNDARIES OF THE NATIVE VILLAGE OF LARSEN BAY SHALL BE THE SAME AS AND COINCIDENTAL TO THE BOUNDARIES OF THE NU NACH PIT, INC.

ARTICLE III - MEMBERSHIP

SECTION I - ALL NATIVE PERSONS WHOSE NAMES SHALL APPEAR ON THE MEMBERSHIP ROLL AND BEING RESIDENTS WITHIN THE GEOGRAPHICAL COVERAGE OF THE NATIVE VILLAGE OF LARSEN BAY FOR AT LEAST SIXTY (60) DAYS OF EACH YEAR SHALL BE MEMBERS OF THE ORGANIZATION OF THE NATIVE VILLAGE OF LARSEN BAY.

SECTION 2 - A NEW MEMBERS. ALL CHILDREN OF ANY MEMBER, WHO ARE RESIDENTS OF LARSEN BAY SHALL BE MEMBERS OF THIS ORGANIZATION.

B ANY NATIVE PERSON WHO BECOMES A RESIDENT OF LARSEN BAY MAY BE ADOPTED AS A MEMBER OF THE ORGANIZATION BY THE TRIBAL COUNCIL BY A MAJORITY VOTE IN ANY OF ITS REGULAR MEETINGS.

SECTION 3 - DEFINITION OF ADULT - ANY NATIVE PERSON WHO IS 18 YEARS OF AGE OR OLDER WILL BE CONSIDERED AN ADULT, AND WILL BE ELIGIBLE TO VOTE AT THE ANNUAL OR SPECIAL ELECTIONS OF THE NATIVE VILLAGE OF LARSEN BAY.

ARTICLE IV - THE TRIBAL COUNCIL

SECTION 1 - THE TRIBAL COUNCIL SHALL BE THE GOVERNING BODY OF THE NATIVE VILLAGE OF LARSEN BAY, ALASKA.

SECTION 2 - THERE SHALL BE A TRIBAL COUNCIL COMPOSED OF SEVEN (7) MEMBERS, ELECTED BY AT LEAST 30% OF THE ADULT MEMBERS OF THE NATIVE VILLAGE OF LARSEN BAY.

SECTION 3 - THE TRIBAL COUNCIL SHALL REPRESENT THE NATIVE VILLAGE OF LARSEN BAY IN ALL ITS UNDERTAKINGS WITH ALL APPROPRIATE GOVERNMENT AND PRIVATE AGENCIES RESPONSIBLE FOR ADMINISTERING PROGRAMS THAT INVOLVE GRANTS AND CONTRACTS TO LEGALLY RECOGNIZED INDIAN TRIBAL GOVERNMENTS AND SHALL EXERCISE THE POWERS OF THE NATIVE VILLAGE OF LARSEN BAY ENUMERATED IN THIS CONSTITUTION.

SECTION 4 - EACH MEMBER OF THE TRIBAL COUNCIL SHALL SERVE FOR A THREE (3) YEAR TERM EXCEPT THAT OF THE MEMBERS FIRST ELECTED, TWO SHALL SERVE FOR A TERM OF ONE (1) year and two shall serve a term of two (2) AND THREE SHALL SERVE A TERM OF THREE (3) YEARS.

SECTION 5 - NOMINATIONS FOR SEATS ON THE TRIBAL COUNCIL SHALL BE OPEN THIRTY (30) DAYS PRIOR TO THE ELECTION AND SHALL BE CLOSED AT 5:00 PM, FIVE (5) WORKING DAYS PRIOR TO THE ELECTION DATE.

ARTICLE V - ENUMERATED POWERS OF THE COUNCIL

SECTION 1 - TO NEGOTIATE AND CONSULT WITH FEDERAL, STATE AND LOCAL GOVERNMENTS ON ALL TRIBAL MATTERS.

SECTION 2 - TO EMPLOY ATTORNEYS, CONSULTANTS AND AGENTS.

SECTION 3 - TO PREVENT ANY SALE OR LEASE OF TRIBALLY OWNED LAND WITHOUT THE CONSENT OF THE TRIBE.

SECTION 4 - TO RECEIVE AND MAKE ANY RECOMMENDATIONS OR APPROPRIATION ESTIMATES FOR THE NATIVE VILLAGE OF LARSEN BAY.

SECTION 5 - TO MAKE ASSIGNMENTS OF TRIBAL LANDS.

SECTION 6 - TO MANAGE TRIBAL PROGRAM AND ECONOMIC ACTIVITIES.

SECTION 7 - TO APPROPRIATE LAND.

SECTION 8 - TO LEVY TAXES AND LICENSE FEES.

SECTION 9 - TO DETERMINE TRIBAL MEMBERSHIP.

SECTION 10 - TO CHARTER AND REGULATE SUBORDINATE ORGANIZATIONS AND COOPERATIVE ASSOCIATIONS.

SECTION 11 - TO ENCOURAGE ARTS AND CRAFTS.

SECTION 12 - TO REGULATE TRIBAL ELECTIONS.

SECTION 13 - TO DETERMINE THE OPERATING PROCEDURES OF THE TRIBAL COUNCIL.

SECTION 14 - TO DELEGATE ANY OF THE ABOVE POWERS TO SUBORDINATE OFFICERS, COMMITTEES, OR COOPERATIVE ASSOCIATIONS.

SECTION 15 - BY-LAWS, THE TRIBAL COUNCIL SHALL ESTABLISH AND ADOPT BY-LAWS PURSUANT TO THE PROVISIONS OF THIS CONSTITUTION AND SHALL HAVE THE POWER TO AMEND ITS BY-LAWS AT ANY DULY CALLED MEETING OF THE TRIBAL COUNCIL, PROVIDING THAT THE NOTICE OF MEETING STATES THAT THE PURPOSE OF THE MEETING INCLUDES THE PROPOSED AMENDMENT OF THE BY-LAWS AS AN AGENDA ITEM.

ARTICLE VI - AMENDMENTS OF CONSTITUTION

SECTION 1 - THE CONSTITUTION MAY BE AMENDED AT ANY MEETING OF MEMBERS OF THE NATIVE VILLAGE OF LARSEN BAY BY A Two-Thirds MAJORITY VOTE OF THE VILLAGE MEMBERS VOTING IN THE ELECTION FOR THE PURPOSE, PROVIDED AT LEAST 30% OF THE VOTING MEMBERSHIP TAKE PART. NO AMENDMENT TO THE CONSTITUTION SHALL BE MADE AT ANY MEETING UNLESS NOTICE IS GIVEN AT LEAST THIRTY (30) DAYS PRIOR TO SUCH MEETING, STATING THAT IT IS PROPOSED THAT THE ARTICLES OF THE CONSTITUTION BE AMENDED AND STATING THE NATURE OF THE AMENDMENT.

ARTICLE VII - ADOPTION OF CONSTITUTION

THIS CONSTITUTION SHALL BE IN EFFECT WHEN IT IS VOTED ON BY A MAJORITY OF THE VILLAGE MEMBERS VOTING IN AN ELECTION CALLED FOR THE PURPOSE; PROVIDED THAT AT LEAST THIRTY PERCENT OF THE VOTING MEMBERSHIP TAKE PART. THE PERSONS ENTITLED TO VOTE ARE ALL THE ADULT MEMBERS (18 YEARS OR OVER) OF THE NATIVE VILLAGE OF LARSEN BAY, AK.

CERTIFICATION OF ADOPTION

WE, THE UNDERSIGNED OFFICERS OF THE NATIVE VILLAGE OF LARSEN BAY HAVING BEEN ELECTED AS COUNCILMEN AND OFFICERS, DO HEREBY CERTIFY THAT WE WERE PRESENT AT AN ELECTION CALLED FOR THE PURPOSE OF ADOPTING THIS CONSTITUTION ON NOV 2, 1982; THAT THE FOREGOING WAS DULY ADOPTED AT SUCH ELECTION BY A VOTE OF 32 FOR, AND 14 AGAINST, WHERE AT LEAST 30% OF THOSE ENTITLED TO VOTE, CAST THEIR BALLOTS.

PRESIDENT

ATTEST: Malcom M. Ge

SECRETARY

BY-LAWS
OF
THE NATIVE VILLAGE OF
LARSEN BAY, AK.

ARTICLE I - OFFICERS AND ELECTION OF OFFICERS

SECTION 1 - THE OFFICERS OF THE TRIBAL COUNCIL SHALL CONSIST OF A PRESIDENT, VICE-PRESIDENT, SECRETARY AND TREASURER. THERE SHALL BE THREE TRIBAL COUNCIL MEMBERS AT LARGE.

SECTION 2 - THE OFFICERS OF THE TRIBAL COUNCIL SHALL BE ELECTED BY AND OF THE TRIBAL COUNCIL. THE ELECTION OF THE OFFICERS SHALL BE HELD IMMEDIATELY AT THE COUNCIL MEETING FOLLOWING THE ELECTION OF THE COUNCIL, DURING THE ANNUAL MEMBERSHIP MEETING.

ARTICLE II - DUTIES OF OFFICERS

SECTION 1 - THE PRESIDENT - THE PRESIDENT OF THE TRIBAL COUNCIL SHALL PRESIDE OVER ALL MEETINGS OF THE COUNCIL AND OF THE MEMBERSHIP, EXERCISING THE USUAL DUTIES OF A CHAIRMAN AND ANY OTHERS WHICH MAY FROM TIME TO TIME, BE DELEGATED TO HIM BY THE TRIBAL ~~COUNCIL.~~ HE MAY VOTE IN COUNCIL MEETINGS ONLY IN CASE OF A TIE. THE PRESIDENT IS CHARGED WITH THE GENERAL AUTHORITY AND RESPONSIBILITIES AS PROVIDED FOR IN THIS CONSTITUTION AND BY-LAWS AND AS MAY BE PROVIDED FOR BY APPROPRIATE GOVERNMENT LAWS OR REGULATIONS. THE PRESIDENT, OR HIS DESIGNEE, SHALL BE THE REPRESENTATIVE TO THE BOARD OF DIRECTORS OF THE KODIAK AREA NATIVE ASSOCIATION ON BEHALF OF THE NATIVE VILLAGE OF LARSEN BAY.

SECTION 2 - THE VICE-PRESIDENT - THE DUTIES OF THE VICE-PRESIDENT, IN THE ABSENCE OF THE PRESIDENT, SHALL BE THE SAME AS THOSE OF A PRESIDENT.

SECTION 3 - THE SECRETARY - THE SECRETARY SHALL ACT AS A CHAIRMAN IN THE EVENT THE PRESIDENT OR THE VICE-PRESIDENT IS ABSENT FROM THE VILLAGE. HE OR SHE SHALL CONDUCT ALL CORRESPONDENCE AND KEEP A COMPLETE AND ACCURATE RECORD OF ALL BUSINESS TRANSACTIONS OF THE ORGANIZATION OR OF THE COUNCIL. HE OR SHE SHALL RECORD ALL RULES AND REGULATIONS IN APPROPRIATE BOOKS FOR THE INFORMATION AND GUIDANCE OF THE VILLAGE MEMBERS. THE SECRETARY SHALL KEEP OR CAUSE TO BE KEPT, CURRENT AND UPDATED, THE TRIBAL MEMBERSHIP ROLL AND WILL REPORT THE ROLL TO THE COUNCIL AT EACH MEETING.

SECTION 4 - THE TREASURER - THE TREASURER SHALL ACCEPT, RECEIVE, RECEIPT FOR, PRESERVE AND SAFEGUARD ALL FUNDS FOR WHICH THE COUNCIL IS RESPONSIBLE. HE OR SHE SHALL MAKE OR CAUSE ACCURATE RECORD OF SUCH FUNDS TO BE KEPT AND SHALL REPORT TO THE COUNCIL ALL RECEIPTS AND EXPENDITURES AND THE AMOUNTS AND NATURE OF ALL FUNDS IN HIS POSSESSION OR CUSTODY. HE OR SHE SHALL NOT PAY OR AUTHORIZE DISBURSEMENT OF ANY FUNDS FOR WHICH HE OR SHE IS RESPONSIBLE EXCEPT UPON AUTHORIZATION OF THE COUNCIL. THE TREASURER MAY BE REQUIRED AT THE DIRECTION OF THE COUNCIL, TO GIVE BOND SATISFACTORY TO THE COUNCIL.

SECTION 5 - APPOINTIVE OFFICERS AND AGENTS - THE DUTIES OF ALL APPOINTIVE OFFICERS, AGENTS OR COMMITTEES APPOINTED BY THE COUNCIL SHALL BE CLEARLY DEFINED BY A RESOLUTION OF THE COUNCIL AT THE TIME OF APPOINTMENT. NO APPOINTIVE OFFICER OR AGENT SHALL SERVE FOR A TERM LONGER THAN THE ELECTIVE OFFICERS.

SECTION 6 - THE RECORDS - ALL ACCOUNTS, RECORDS, BOOKS AND MINUTES OF THE NATIVE VILLAGE OF LARSEN BAY OR TRIBAL COUNCIL MEETINGS SHALL BE SUBJECT TO EXAMINATION BY MEMBERS OF THE VILLAGE OR COUNCIL, OR AGENTS OF THE APPROPRIATE GOVERNMENT AGENCIES HAVING AUTHORIZED BUSINESS WITH THE NATIVE VILLAGE OF LARSEN BAY.

ARTICLE III - QUALIFICATION OF OFFICERS

SECTION 1 - NO PERSON MAY BE A CANDIDATE FOR ANY ELECTIVE OFFICE UNLESS HE IS AN ADULT PURSUANT TO THE PROVISIONS OF THIS CONSTITUTION AND BY-LAWS.

SECTION 2 - NO PERSON WHO HAS BEEN CONVICTED OF A FELONY MAY BE A CANDIDATE FOR ANY ELECTIVE OFFICE FOR A PERIOD OF TEN YEARS FROM THE DATE OF HIS CONVICTION.

SECTION 3 - ELECTION JUDGES - THE TRIBAL COUNCIL SHALL APPOINT THREE ELECTION JUDGES WHOSE DUTY SHALL BE TO COORDINATE THE ELECTION OF TRIBAL COUNCILMEN AND REPORT THE RESULTS TO THE MEMBERSHIP.

ARTICLE IV - MEETINGS OF THE COUNCIL

SECTION 1 - ALL MEETINGS SHALL BE SCHEDULED BY RESOLUTION OF THE TRIBAL COUNCIL OR AT THE CALL OF THE PRESIDENT. WRITTEN NOTICE SHALL BE GIVEN TO THE MEMBERS OF THE COUNCIL AT LEAST THREE (3) DAYS PRIOR TO THE MEETING. SUCH NOTICE SHALL BE POSTED IN A PUBLIC PLACE. THE COUNCIL MEETINGS SHALL BE OPEN TO THE MEMBERSHIP OF THE NATIVE VILLAGE OF LARSEN BAY.

SECTION 2 - THE PRESIDENT MAY CALL SPECIAL MEETINGS AS HE MAY DEEM NECESSARY BY GIVING TWO (2) DAYS NOTICE TO THE MEMBERS OF THE COUNCIL.

SECTION 3 - THE QUORUM - FOUR (4) COUNCIL MEMBERS SHALL CONSTITUTE A QUORUM FOR A COUNCIL MEETING. FOR GENERAL MEMBERSHIP MEETINGS, THIRTY PERCENT (30%) OF THE MEMBERSHIP SHALL CONSITTUTE A QUORUM.

SECTION 4 - CAREFUL AND ACCURATE RECORD IN THE FORM OF MINUTES SHALL BE KEPT OF ALL MEETINGS OF THE MEMBERSHIP AND THE COUNCIL AND SHALL BE PRESERVED IN THE APPROPRIATE FILES OF THE COUNCIL.

SECTION 5 - VACANCIES - THE MAJORITY OF THE REMAINING TRIBAL COUNCILMEN SHALL FILL ANY VACANCY BY ELECTION AND THE PERSON ELECTED SHALL SERVE FOR THE DURATION OF THE TERM OF THE PERSON VACATING THAT OFFICE.

ARTICLE V - MEETINGS OF THE MEMBERSHIP

[illegible] 7-2-61

SECTION 1 - ANNUAL MEMBERSHIP MEETING - AN ANNUAL MEETING OF THE MEMBERS SHALL BE HELD FOR THE PURPOSE OF ELECTING COUNCIL MEMBERS WHOSE TERMS HAVE EXPIRED AND FOR TRANSACTION OF SUCH OTHER BUSINESS AS MAY COME BEFORE THE MEETING.

SECTION 2 - VOTING PROCEDURES - ALL MEMBERS NOT PRESENT AT THE ANNUAL MEETING, BUT PRESENT WITHIN THE VILLAGE, MAY BE CANVASSED BY THE ELECTION JUDGES IN ORDER THAT THESE MEMBERS MAY CAST THEIR BALLOTS FOR THE ELECTION OF THE TRIBAL COUNCIL.

SECTION 3 - THE ANNUAL MEMBERSHIP MEETING SHALL BE SET BY RESOLUTION OF THE TRIBAL COUNCIL.

ARTICLE VI - RIGHTS OF THE MEMBERS

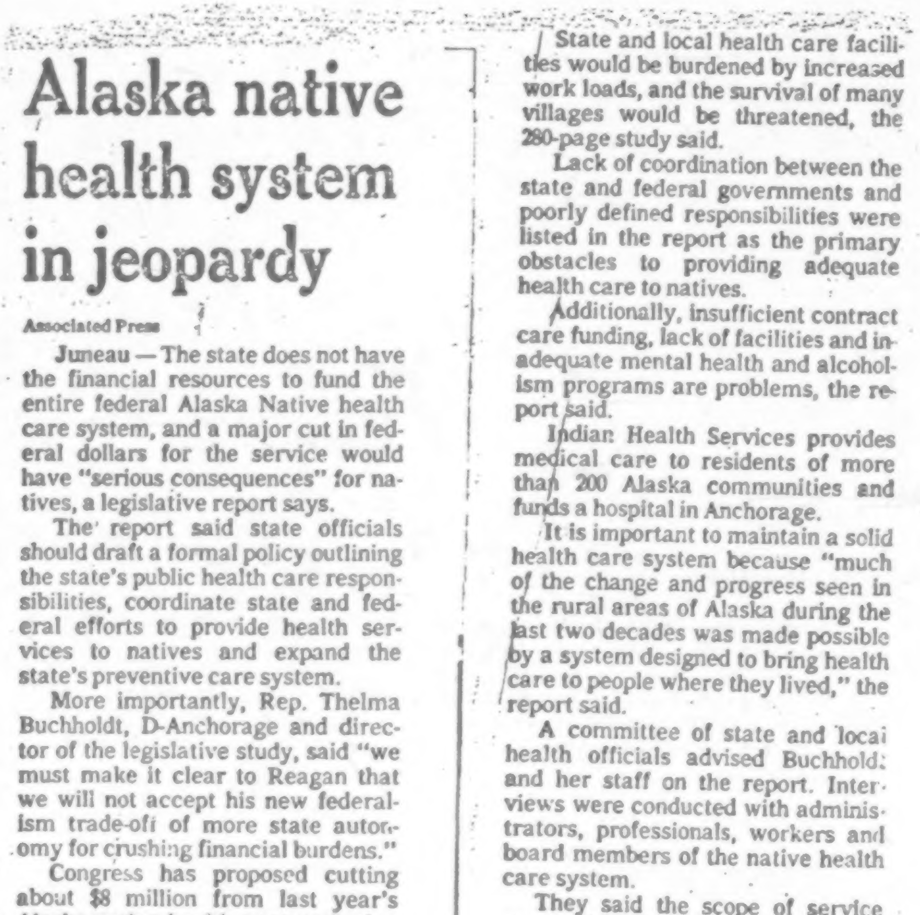
SECTION 1 - ALL MEMBERS OF THE NATIVE VILLAGE OF LARSEN BAY, 18 YEARS OR OVER, SHALL HAVE THE RIGHT TO VOTE IN VILLAGE MEETINGS AND ELECTIONS.

SECTION 2 - MEMBERS OF THE NATIVE VILLAGE OF LARSEN BAY SHALL HAVE THE RIGHT TO SPEAK AND MEET FREELY IN A PEACEABLE MANNER.

SECTION 3 - MEMBERS OF THE NATIVE VILLAGE OF LARSEN BAY SHALL HAVE EQUAL CHANCE TO SHARE IN THE BENEFITS OF THE VILLAGE.

ARTICLE VII - RULE-MAKING POWER

THE COUNCIL SHALL HAVE POWER TO MAKE RULES AND REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS CONSTITUTION AND BY-LAWS.



Alaska native health system in jeopardy

Associated Press

Juneau — The state does not have the financial resources to fund the entire federal Alaska Native health care system, and a major cut in federal dollars for the service would have "serious consequences" for natives, a legislative report says.

The report said state officials should draft a formal policy outlining the state's public health care responsibilities, coordinate state and federal efforts to provide health services to natives and expand the state's preventive care system.

More importantly, Rep. Thelma Buchholdt, D-Anchorage and director of the legislative study, said "we must make it clear to Reagan that we will not accept his new federalism trade-off of more state autonomy for crushing financial burdens."

Congress has proposed cutting about $8 million from last year's Alaska native health care operating budget of $96 million, the report said.

Legislative aides predicted the deepest cuts would be in funding for preventive health care. Also, residents living in outlying areas would have less money to travel to centrally located health care facilities, and physicians would have to cutback on visits to patient living in remote areas.

The $86,000 report for the House Finance Committee was released Wednesday.

"Any major reduction in congressional appropriations for the native health care system would have serious consequences for Alaska Natives and the state as a whole. Great stress would be put on other medical facilities as village residents would be forced to seek medical care away from their villages," the report said.

State and local health care facilities would be burdened by increased work loads, and the survival of many villages would be threatened, the 280-page study said.

Lack of coordination between the state and federal governments and poorly defined responsibilities were listed in the report as the primary obstacles to providing adequate health care to natives.

Additionally, insufficient contract care funding, lack of facilities and inadequate mental health and alcoholism programs are problems, the report said.

Indian Health Services provides medical care to residents of more than 200 Alaska communities and funds a hospital in Anchorage.

It is important to maintain a solid health care system because "much of the change and progress seen in the rural areas of Alaska during the last two decades was made possible by a system designed to bring health care to people where they lived," the report said.

A committee of state and local health officials advised Buchholdt and her staff on the report. Interviews were conducted with administrators, professionals, workers and board members of the native health care system.

They said the scope of service provided through the native health care system is good, though access to care frequently is blocked by inadequate resources. Increased coordination between federal and state programs and a more secure financing system would improve the quality of care considerably, they said.

UNIVERSITETS
ANTHROPOLOGISKE LABORATORIUM
NØRRE ALLÉ 63 . 2100 KØBENHAVN Ø

Den 28.04.1983

Dear Frank and Jeannie.

Thank you for your hospitality in Larsen Bay.

The success of our work depended very much on your great help and understanding.

I have considered the proposal of retiring to Larsen Bay, but it must at least wait a couple of years.

On the other hand, I have told so many great stories about Larsen Bay to my staff here, that some young doctors have asked if I eventuality could arrange a stay for one of them in Kodiak Island for a year or so.

Would you think that worth-wile?

Once more thank you for my fine time in Larsen Bay.

J. Balslev Jørgensen

Senator MURKOWSKI. Thank you very much, Mr. Peterson. That concludes the panel.

I would like to pose a question for your response, either individually or collectively in regard to prioritizing the most difficult problem. Do you generally agree it is alcoholism and drug abuse, and do you feel it is getting better or worse?

Ms. Curtis, would you care to respond?

Ms. CURTIS. Senator Murkowski, in our respective villages emergency is coming up high because of alcoholism and drug abuse.

Senator MURKOWSKI. Is it getting better or worse?

Ms. CURTIS. It is getting worse.

Senator MURKOWSKI. Do you feel it is getting worse, Eleanor?

Ms. MCMILLAN. Yes. I feel that alcohol is the highest priority on our health committee's list. We had to revise that after 5 years, but anyway it is getting better, I feel, through the program that the man mentioned down here, "Here's Looking At You". It is an awareness program we have now to work through the school system. I feel like it is an improvement; the children take it home, they hear about it in school, they take it home to their families.

Senator MURKOWSKI. What about drugs?

Ms. MCMILLAN. Drugs, the same way.

Senator MURKOWSKI. Is it getting better?

Ms. MCMILLAN. It is increasing during the summer months because of the influx of the people, of transient workers. During the winter months, it seems to stabilize.

We still have our regular users, though.

Senator MURKOWSKI. Any other differences of opinion? We have one who says it is better, and one who says it is worse.

Ms. Gray?

Ms. GRAY. I think the drug problem is getting worse out there due to the influx of the transient population. The mix is of drugs and alcohol together. The results that I come up with at the clinic with that, I would say about 30 percent of the people that I see through the clinic are either drug-related or alcohol-related.

Senator MURKOWSKI. It has been suggested that a large amount of drugs that are transmitted into the smaller communities come in first-class mail. Do you have any observation of that?

Ms. GRAY. I know it does.

Senator MURKOWSKI. I appreciate that. That is a contention that is expressed by many Alaskans. Unfortunately, the Postal Department is not set up to have postal inspectors available when it is suspected that drugs might be concealed in first class mail and there has been an inability of the enforcement agencies to really work together. The Post Office has an obligation to keep the privacy and confidentiality of the mails, and they are reluctant to bring in State agencies such as the troopers and others, and that is something which we are working on.

I met with postmasters and postmistresses yesterday, and I am going to be meeting with the postal authorities in Washington and see if we cannot begin to curb this. While we have a responsibility for confidentiality of the mail, the mails were not set up to allow the movement of narcotics through first-class mail. But that is another subject.

Anyone else?

Mr. CHARLES. Yes, Senator Murkowski. I would like to make a comment on alcohol and drug abuse. Personally, I believe the problem is getting worse, because I believe that the prevention aspects are good and well for what they are, but because of limited funding and inadequate personnel to serve the people I believe that there is a core of the problem. I believe very strongly that education and educating people in general about drug and alcohol abuse will stem the tide of the problem here in Alaska.

However, I would like to see increased funding of drug and alcohol programs in the State of Alaska so as to create more innovative programs such as "Here's Looking At You." I believe that is the direction it needs to go.

Senator MURKOWSKI. Are the churches in the villages, or the private sector, making effective contributions to fight alcohol and drug abuse?

Ms. CURTIS. Yes, the churches do help, but in the 10 villages in our area, alcohol consumption is banned, though there is still alcohol coming in and drug abuse is still increasing.

Senator MURKOWSKI. I want to thank the panel. I think your testimony has been very, very valuable in providing us with an insight into the problems that you relate to, and we certainly want to compliment you for your commitment and dedication. You certainly provide a very necessary and worthwhile service under very, very difficult conditions. We appreciate that.

Our final panels are panel four, Indian Health Service, and panel five, Village Sanitation. We are going to combine panels in the interest of time because I do feel that we can conclude the hearing prior to about noon. It is 11:25 now.

The combined panel will be Gerry Ivey; Dr. Stu Rabeau, director, Division of Public Health; Greg Capito, Department of Environmental Conservation; Rhonda Roberts, special assistant to Governor Sheffield; and Senator Joe Josephson who was going to testify. I do not know that Joe is here.

We welcome you to the witness table and we look forward to your testimony.

We will start with Rhonda Roberts, special assistant to Governor Sheffield. I believe you have a message from our Governor, and we would appreciate your directing your remarks to the Chair. If you would like to summarize anything in the interests of time that would be appreciated. I will hold you to the 5-minute time limit.

STATEMENT OF RHONDA ROBERTS, SPECIAL ASSISTANT TO BILL SHEFFIELD, GOVERNOR, STATE OF ALASKA

Ms. ROBERTS. I have a letter from the Governor that I would like to read.

DEAR SENATOR MURKOWSKI: Thank you for the opportunity to present my Administration's views on the current status of the Indian health care in the State of Alaska. By your presence, and under the aegis of Chairman Mark Andrews, you have brought the concerns of the Alaska Native community into the forefront and have allowed for the active participation of those most concerned with the availability and quality of health care to the American Indians and Alaska Natives in our state.

I would like to briefly state by immediate concerns and invite you and the other participants in today's hearings to continue an open and, we hope, productive dialogue.

There are three principal areas of concern that my Administration has. These are:

a. Full reauthorization of the Indian Health Care Improvement Act of 1976, with adequate levels of funding in order to meet the concerns of individual communities, the regional health corporations and the IHS hospital entities.

b. The need for a clearer definition of roles between the state and federal government, and between the federal government and tribal entities in the aggressive pursuit of epidemiologic and primary diagnostic care for persons in remote areas and small communities, to wit: that future identified epidemics such as the current hepatitis B outbreak will be resolved in a fair, equitable and timely manner through cooperative programs.

c. The need for the federal government to increase its capacity to provide primary sanitation services and safe water to those eligible communities still in need of those services, in order that the State of Alaska will not be tasked with sole responsibility for services clearly beyond its capacity. Additionally, the treatment of raw sewage in an arctic environment must be recognized by the United States government as a major problem requiring their full participation in its resolution.

Mr. Chairman, the State of Alaska clearly recognizes the limitations of available dollars to achieve many desirable purposes, but must strongly emphasize that the federal government clearly carries a responsibility for the health, welfare and well-being of the Indian people.

In the past six months of my Administration, I have encountered two disturbing examples of how the federal government is apparently violating its public trust responsibiliity. You are personally aware of the issues concerning the Bureau of Indian Affairs' termination of the boarding school program at Mt. Edgecumbe High School. Through your able efforts and the work of my Administration, efforts are being made to continue use of that facility in order that the "higher horizons" that that educational facility provided to Alaskan Natives will not be lost. Had we not sought relief in the face of the impending closure, the federal government would have vacated the facility and left nothing in its place.

Additionally, the federal government has determined that it will end its operation of the fur seal harvest in the Pribilof Islands effective October 1, 1983. The Pribilof Islands residents, since their relocation to the islands to harvest the fur seals, have been provided for totally by the federal government. The proposal by the U.S. Department of Commerce will leave the Pribilovians without federal support and with a plan for economic diversification which cannot be fully implemented for three to five years. The government in this situation has created a dependency that is to disappear October 1, and has a moral obligation to the people of the Pribilof Islands. I am in support of the efforts of the Pribilovians to receive fair treatment by the federal government. I have committed state resources toward their future development, and will continue to work with them to ensure a fair and just settlement by the federal government.

At the outset, I spoke of three principal concerns that I have concerning health care for Alaska's Native peoples, but I would also like to raise a cautionary note for something that I perceive on the horizon. That issue is what portends for the Indian Health Service in years to come? Will we be advised at some point in the future that this trust relationship, too, will come to an end at the close of a fiscal year? Will the State suddenly become the recipient of another 'block grant' to assume full responsibility for these people, only to find that the grant will be inadequate to address the problems? Or will the tribal entities be delegated responsibility for providing health care services as the individual states would, but without the resources or revenues available to them?

Senator, I expect from the testimony provided by Dr. Rabeau for the Department of Health and Social Services, and Mr. Capito from the Department of Environmental Conservation, that the specifics of my concern will be addressed. I regret that I am unable to be present with you to further review and discuss these issues, but look forward to a continuing exchange on these matters.

Thank you for this opportunity.

Sincerely,

BILL SHEFFIELD, *Governor.*

Senator MURKOWSKI. Thank you very much, Rhonda. We appreciate your delivering that message for the Governor.

I think that your message is one that we have a constant awareness of. One of the difficulties that we have in regard to the situation in the Pribilofs is the recognition that those residents, while having been in effect wards of the Federal Government, are Alaskans as well and that what we are really talking about is a matter of funding. Hopefully, it is going to be resolved in a manner that is suitable with the dignity that should be extended in this transfer of authority from the Federal Government. You can assure Governor Sheffield of the wholehearted support and the commitment of the delegation in working with the State in resolving this and other problems that he has identified in his testimony.

Gerry Ivey will be the next witness.

STATEMENT OF GERALD H. IVEY, AREA DIRECTOR, ALASKA AREA NATIVE HEALTH SERVICE

Mr. IVEY. Thank you, Senator.

My name is Gerald Ivey, and I am director of the Alaska Native Health Service. I have a formal statement which I would like to insert into the record.

Senator MURKOWSKI. It will be entered as if read.

Mr. IVEY. It outlines some of the challenges and the progress of the Alaska Native Health Service. Rather than read it, I will be available for questions that you might have.

[The prepared statement follows:]

PREPARED TESTIMONY OF THE INDIAN HEALTH SERVICE, ALASKA AREA NATIVE HEALTH SERVICE, GERALD H. IVEY, AREA DIRECTOR

The Indian Health Care Improvement Act, enacted on September 30, 1976, represents a major commitment by the Congress in defining the scope of the Indian Health Service program. The purpose of this testimony is to report on the progress that has taken place in the Alaska Area as a result of this Act and to lend our support to the reenactment of this very important legislation for the health of the Alaska Native people.

The Alaska Area Native Health Service (AANHS) is the primary Federal health resource for the 68,692 Alaska Native people in the Alaska Area which encompasses the State of Alaska. The program provides a comprehensive organized health program of preventive, curative, rehabilitative and environmental services. The health program is organized in Alaska into a multilevel delivery system with the Community Health Aide as the primary provider of care at the community level. The second level of care is a system of six regional general medical and surgical hospitals and five fully staffed health centers. The tertiary level of services is centered in the Alaska Native Medical Center in Anchorage, Alaska.

The goal of the Alaska Area Native Health Service is to elevate the health status of Alaska Native people to the highest possible level. The highest priority is to assure the availability of high quality health services through a system of effective facilities operated directly by the Indian Health Service and Alaska Native organizations by contract. The purpose of Public Law 93-638, the Indian Self-Determination and Education Assistance Act, is to provide increasing opportunities and assistance to Alaska tribes and tribal organizations to manage and operate the programs and facilities of the AANHS. In Alaska it is readily apparent that the Alaska Native people through their Regional Health Corporations and Village tribal governments are willing and capable of assuming responsibility for the organization and delivery of health care. At present, almost one-third of the health programs and facilities in Alaska are under the operation of tribal and Regional Health Corporations through contracts exceeding $25 million.

In addition to providing an increasing number of health services throughout Alaska, the Regional Health Corporations in Alaska manage a large variety of programs in the State of Alaska. The people in Alaska are fortunate in that the State has historically provided health services to rural villages as well as urban areas. Therefore, the Alaska Native people have benefited from programs in public health nursing, communicable diseases, chest diseases, cardiac clinics in addition to the traditional state-federal programs in maternal and child health, vocational rehabilitation, cleft palate and others. In more recent years the State has implemented the optional benefits available under the Medicaid program including coverage for the medically needy. The State has also funded separate programs for catastrophic illness and the General Relief Medical program to provide services not covered by Medicare or Medicaid. The Alaska Native tribal organizations operating facilities owned by them or operated under P.L. 93–638 contracts are eligible to bill the various state programs for services provided.

One of the important legislative changes for the Alaska Area is Public Law 94–437. The application of the provisions of this law have, for example provided 37 scholarships for Alaska Native students to pursue studies in the health professions. Probably the most important provision is Title IV, Access to Health Services under the Medicare and Medicaid programs. More and more Alaska Natives are availing themselves of medical care under these programs. The payments for services provided in Alaska Area facilities have provided ever increasing financial improvements in these facilities. In F.Y. 1982, the Alaska Area benefited from more than $5.4 million in collections resulting in improved ability to meet JCAH standards.

Over the past five years the Alaska Area has continued to expend considerable effort improving the delivery of health services, even in times of high inflation and restricted resources. The Alaska Area is involved in an evaluation of the Patient Care Information System (PCIS) which is the backbone of the medical information system. In Alaska, PCIS is a joint effort with the State of Alaska whereby medical information is shared resulting in a comprehensive record of each person treated in an IHS facility, private facility under the contract care program or the various programs of the Alaska Dept. of Health and Social Services. In addition, valuable statistical information is economically captured and the PCIS is the basis for an automated Medicare and Medicaid billing system.

In spite of inflation during the last five years, the Alaska Area Native Health Service has accomplished significant program improvements. Since 1977, the Alaska Area Native Health Service Budget has increased by approximately 62 percent from $59,574,400 in 1977 to $96,357,000 in 1982. During that period the Budget has increased every year with the exception of fiscal year 1982 when a 0.87 percent decrease was experienced. While much of this increase has been eroded because of inflation, the health care program has improved and been transformed into a more effective health maintenance and delivery system for Alaska Natives. Evidence of this continued growth is exhibited by a few of the more significant program improvements that have occurred during the past several years.

SATELLITE COMMUNICATION PROGRAM

Use of commercially available satellite communications in Alaska became possible in 1976 when initial funding was provided. This type of reliable and quality communications service fulfills a critical need in Alaska due to the extreme remoteness of the many villages from the medical facilities. In 1977, AANHS received an additional $500,000 to expand this program. Currently this service is provided to the eight regional hospitals and 57 villages in the most remote locations of the state. This network provides a means to conduct daily routine medical communications as well as emergency medical responses.

FAIRBANKS CLINIC

A substantial increase in medical and dental service capability at the Fairbanks ANHS Health Center was provided in 1978 as a result of a specific appropriation of $430,000 for this facility. This made possible the renovation and expansion of the existing facility by 5,000 square feet, plus the addition of thirteen new personnel to provide the increased medical and dental services.

NOME HOSPITAL

The Norton Sound Regional Hospital opened its doors to the public on March 3, 1978. Official dedication ceremonies were on April 29, 1978. The funding came through a $5 million Federal grant and a matching 80–20 grant from the State. Additional resources were made available through the Indian Health Service. The $7.2 million 24 bed structure was built with an eye to the future, demanding that every feature of the new hospital be compact, versatile, expandable and long-lasting.

FORT YUKON

Medical services provided at Ft. Yukon were increased in 1979 with $200,000 specifically appropriated for Ft. Yukon which included a replacement facility leased from the city of Ft. Yukon and four additional medical positions. This upgrade from a health clinic to a health center program is operated under a P.L. 93–638 contract with the Tanana Chiefs Conference.

VILLAGE BUILT CLINIC PROGRAM

The Village Built Clinic Program provides means to lease village owned clinics from the Native villages throughout Alaska to provide a facility for use by our field physicians and village health aides. This program began in 1972 and presently funds over 130 leased village clinics with an annual budget of $1,160,000.

YUKON-KUSKOKWIM DELTA HOSPITAL

Ribbon-cutting dedication ceremonies of the new $32.5 million Yukon-Kuskokwim Delta Hospital at Bethel, Alaska took place in August, 1980. The 95,000 square-foot, 50 bed hospital opened its doors in early September. It is a complete, self-contained regional medical facility. Services include general medical patient care covering both adult and pediatric services and dental care. Full services are available for obstetrical patients and care of their new-born infants. Complete ambulatory care services are provided along with full laboratory and radiology services for both in-patient and ambulatory patients. Fifty-five additional positions were assigned to the hospital. The Yukon-Kuskokwim Delta Service Unit provides health services for approximately 20,000 residents in over 50 villages in the Yukon-Kuskokwim Delta Region and the Bering Sea Coast.

KETCHIKAN CLINIC

In 1980, a substantial increase in medical and dental services at the Ketchikan Health Center was made possible by a specific congressional appropriation of $459,000 and 12 new positions. This allowed the consolidation and expansion of the medical and dental programs into a modern facility through a lease agreement.

BETHEL QUARTERS

In fiscal year 1980, $4,467,000 was appropriated for construction of 40 new housing units adjacent to the new Yukon-Kuskokwim Delta Hospital in Bethel, Alaska for housing the additional staff needed for the new hospital. All of these units were completed and occupied in September, 1981. To fulfill the remaining staff housing needs, congressional authority was granted in fiscal year 1981 to lease 47 additional units of housing.

ALASKA NATIVE MEDICAL CENTER

In fiscal year 1980 IHS program funds were provided to complete a feasibility study to purchase the Alaska Hospital in Anchorage. While the study did not result in the purchase of the hospital, it did review and quantify the need for a replacement medical center in Anchorage to serve Alaska Natives. This study was also the basis for determining that the existing Alaska Native Medical Center should be the number one national Indian Health Service priority for replacement. Engineering site studies are presently proceeding to determine the seismic stability of the existing hospital site.

Since 1972, the Alaska Native Health Service and the Center for Disease Control (CDC) in Alaska have been conducting cooperative studies on hepatitis-B in Alaska villages. These studies were culminated by the CDC led hepatitis-B vaccine project conducted in the Yukon-Kuskokwim and Norton Sound Regions. These studies have demonstrated that Yupik speaking Eskimos have the highest incidence of hepatitis-B in the United States. In some villages, up to 27 percent of the inhabitants are carriers of this virus and another 50 percent show evidence of having been infected and recovered. In the same villages as many as 50 percent of children are carrying the virus. Fortunately, a new vaccine has been developed for hepatitis-B. This vaccine has proven to be very effective and thus far very safe. In 1981 and 1982 CDC, IHS and the Yukon-Kuskokwim and Norton Sound health corporations conducted a joint vaccine project in which approximately 1,600 high-risk individuals were vaccinated against hepatitis-B. The vaccine was highly effective and there were no serious side-effects. After this successful project was completed, the Alaska Area Native Health Service developed a program designed to curtail the spread of hepatitis-B in rural Alaska.

In the last year, the State of Alaska, Department of Health and Social Services has joined the Alaska Area Native Health Service in the battle against hepatitis-B. The Alaska Area has obtained $1.0 million in fiscal year 1983 to be used for the hepatitis-B control program of which $500,000 was obtained from a special Congressional appropriation and $500,000 from IHS program funds. The cost of the hepatitis-B control program will be approximately $1.0 million per year for the first three years after which the cost will drop off dramatically.

While health care in the Alaska Area has seen significant improvements in facilities and special programs, the basic medical care system has experienced inflationary cost increases not entirely compensated for by additional appropriations. The Pay Act supplemental for Alaska employees was at 60 percent of cost in fiscal year 1980, 56 percent in fiscal year 1981, and 63.5 percent in fiscal year 1982. Along with employment freezes, this steady erosion of funding has caused a reduction of 200 personnel in the past three years. The health gains of the past 10 years cannot be maintained much longer without appropriations to restore employment to the fiscal year 1980 level.

In other respects the operation of the health system in Alaska has unique problems and unusual costs. All supplies and equipment must be transported from the port of Seattle to remote, difficult, and costly locations. Frequently, warranty and maintenance is not available locally and requires expensive transportation plus costs for these services where in other states the installation and service is included in the purchase. Fuel is a special problem because of high transportation costs, a severe climate and long term storage problems because shipment can only be accomplished in the summer.

In order to maintain access to basic medical care in the facilities of the Alaska Area, certain services had to be curtailed which will have far reaching and detrimental long term effects on people's health. Program funds for patient travel from villages to hospitals has been reduced 57 percent. Medical and dental field trips to village clinics have been reduced 25–50 percent. These two restrictions have their greatest effect on preventive health services with resultant future consequences. Staff development and training of both professional and village workers is another casualty of inflation.

Another of the long term consequences of trying to maintain adequate staff and support for basic medical care is the maintenance and replacement of existing facilities. Without increases to offset inflation, the backlog of facility deficiencies has increased dramatically to over $74.8 million. These deficiencies involve improvements in fire safety, life safety as well as patient care, program, energy reduction and handicapped access. These costs for essential maintenance have increased from $42 million in 1980 to the present cost of almost $75 million.

Despite maintenance efforts over the years, the hospital at Kotzebue requires extensive repairs. Due to permafrost, the hospital is sinking into the melted ice in the ground and the hospital may need replacement. An engineering study is now being carried out to determine if the building can be rehabilitated. Similarly, the hospital at Mt. Edgecumbe, built in 1948, is in need of major modernization and is the object of an extensive study and analysis.

Medical curative and even preventive health care will not solve the basic health problems of Alaska Native people. There is a direct correlation between increased costs of treating disease and improper and poor sanitation. Throughout all of Alaska, basic community services and utilities have yet to be constructed in many communities. Based upon 1981–82 studies, the construction costs of needed basic water, sewer and solid waste disposal systems exceed $162.4 million.

In summary, the health program in Alaska, shared by the Alaska Native Health Service, Alaska Native tribes and Regional Corporations, the private sector and the State of Alaska, is a unique, effective and challenging medical system. Much has been accomplished in its 25 years of existence by the efforts of an impressive list of people. A great deal of effort is necessary to maintain these health gains and preparation to meet future dangers such as hepatitis-B. The Senate Select Committee on Indian Affairs has provided the opportunity to tell again the story of Alaska Health care. The original goal of P.L. 94–437, The Indian Health Care Improvement Act was to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services. Reenactment of this statute will achieve that ideal.

Mr. IVEY. At this time I would like to ask Dr. McMahon to speak about the very severe health problem that you have heard some testimony about today. Dr. McMahon is an internist here on our staff at the medical center and I would like to ask him to present to you some of the concerns that we have about our hepatitis B epidemic, after which I will be available for any questions.

Senator MURKOWSKI. Thank you. Dr. McMahon, please proceed.

STATEMENT OF BRIAN J. McMAHON, M.D., ALASKA AREA NATIVE HEALTH SERVICE, ALASKA NATIVE MEDICAL CENTER, ANCHORAGE, ALASKA

Dr. MCMAHON. Thank you, Senator. Hepatis B virus is a DNA virus that is one of several organisms that causes acute hepatitis or inflammation of the liver in man. About 15 percent of those infected will develop acute clinical hepatitis as characterized by nausea, vomiting, pain in the abdomen, poor appetite, and yellowing of the skin. However, 10 to 15 percent of those infected will become chronic carriers of this virus and will be unable to get rid of it. Hepatitis B is spread by contaminated blood and blood products. The virus is able to remain alive on environmental surfaces for long periods of time. Spread is by close personal contact with infected individuals.

Since 1972, the Alaska Area Indian Health Service and Centers for Disease Control in Alaska have been conducting cooperative studies on hepatitis B in Alaskan villages. These studies have demonstrated that Yupik-speaking Eskimos have the highest incidence of hepatitis B in the United States. In some villages, up to 27 percent of the inhabitants, including 50 percent of children are carriers of this virus, and another 50 percent show evidence of having been infected and recovered. However, in other villages there are no carriers and less than 10 percent of the population has been infected. In other ethnic Native areas, the percentage of carriers ranges from 2 to 5 percent. Evidence shows that this is a newly introduced infection and is spreading slowly from village to village, but rapidly within villages where there is 5 percent of the individuals that are carrying the virus. The percentage of people infected who become chronic carriers is directly related to age. The younger you are infected, the greater chance you have of becoming a carrier. Ninety percent of infants born of infected mothers will themselves become chronic carriers of the virus, and there are four serious complications of carrying hepatitis B for a long period of time.

The first and most devastating of these is primary liver cancer. Since hepatitis B is a DNA virus, it has been shown that it can actually integrate itself into the DNA of the host liver cell and thereby, it is believed, cause cancer. Prospective studies of carriers in Taiwan and Alaska have shown that the risk of developing primary cancer is about 300 to 1 in carriers versus non-carriers.

To put this into perspective, the risk of developing lung cancer in a heavy smoker versus a non-smoker is about 20 or 30 to 1.

Alaskan Eskimos have the highest rate of primary liver cancer in the United States. One-third of those patients are under the age of 30. The CDC has estimated that 1 out of every 10 carriers will develop primary liver cancer during their lifetime, and this is probably a conservative estimate.

The second complication of hepatitis B is nonalcoholic cirrhosis of the liver. It is estimated that one out of every five carriers is likely to develop this often lethal complication.

A third complication of hepatitis B is vasculitis, a severe illness with an immune response to the virus causing inflammation of the small blood vessels in the body, involving renal failure, inflammation of the heart and other complications. It has a 30-percent mortality rate and survivors require long and expensive therapy.

The Yukon-Kuskokwim delta area has the highest incidence of this complication in the world.

And a fourth complication seen in Alaska is glomerulonephritis, an inflammation of the kidney that can lead to renal failure. In some parts of the world, such as Japan and Poland, this is the No. 1 cause of renal failure in children. All these complications can be seen in Alaskan Natives.

The cost of taking care of the patients with acute hepatitis and its complications is mounting in Alaska. If nothing were done, this cost would dramatically increase.

The CDC has estimated that the cost of taking care of a patient who is hospitalized with acute hepatitis is $3,825 on the average. This does not include $2,000 in lost wages. We estimate that there will be approximately 3,650 new cases of hepatitis B in Natives per year. About 15 percent of these will become chronically ill and require medical attention, and the anticipated cost is $270,000 per year. In addition, between 400 and 450 of these individuals will become chronic carriers of hepatitis B. Added to an estimated 3,000 carriers already, you can see that it is going to cost millions of dollars in the future to take care of the complications like cancer and other complications that are developing in these carriers. Therefore, a program to slow down the spread of hepatitis B would have tremendous benefits, not only in human suffering, but also in future health care costs.

Fortunately, a new vaccine has been developed by Merck and Co. that is shown to be very effective against hepatitis B, and also very safe. In 1981 and 1982, the CDC's, Indian Health Service and Yukon-Kuskokwim, and Norton Sound Health Corp. conducted a joint vaccine project in which approximately 1,600 high-risk individuals were vaccinated against hepatitis B. The vaccine was highly effective and there were absolutely no serious side effects. After this successful project was completed, the Alaska Area Native Health Service developed a program which was designed to curtail the spread of hepatitis B. The main features of this program involved vaccinating those who are of highest risk, including newborn infants born of carrier mothers and people who live in houses with carriers of hepatitis B, and those who live in villages in which 5 percent or more of the population are carrying the virus.

In addition, in order to do this, it is estimated that we need to screen about 60,000 Alaskan Natives.

And finally, the fourth part of this program will address people who are unfortunately stuck with carrying this virus. Recently a chemical called alpha-fetaprotein has been found to be elevated in the blood of patients with primary liver cancer up to 2 years prior to the time they become ill with cancer. Studies in Japan, Taiwan, China, and now Alaska have shown that this test can detect cancer in potentially curable stages. Therefore, we propose to test the blood of all those carriers of hepatitis B twice a year to detect, hopefully, the liver cancer in a curable stage.

In the last year, the State of Alaska, Department of Health and Social Services has joined the Alaska Area Native Health Service in the battle against hepatitis B. The Alaska Area Native Health Service has obtained $1 million in fiscal year 1983—$500,000 of that from a special congressional appropriation and $500,000 from year-end moneys to be used in this control program. The State of Alaska has subcontracted to do much of the blood screening and vaccination. The cost of this program to the Federal Government would be approximately $1 million per year for the first 3 years, after which the cost will drop off dramatically. Since this program is now in full gear, it is extremely important that the million-dollar appropriation for the second and third years of the program be obtained; otherwise, there will be a dramatic slowdown in the implementation of this program and greater risk that hepatitis B will spread to Native areas that have not been infected and to urban areas where a majority of Alaska's population resides.

Thank you.

Senator **Murkowski**. Thank you, Doctor. You indicated that you anticipate 3,000 people will be infected this year with hepatitis B?

Dr. **McMahon**. We think that there will be 3,000 new cases, and in addition we already know of 1,200 people who are carrying the virus, and when we test more Alaska Natives we anticipate that there are already 3,000 carriers.

Senator **Murkowski**. What would be the immediate impact of more funds to curb the estimated 3,000 cases?

Dr. **McMahon**. Well, obviously the faster we get this program going the more dramatically it will drop off, and already the State of Alaska has begun its vaccination program and screening program in the worst area, which is the Bethel area, so just by finishing up the Bethel areas, the Norton Sound areas and the Kotzebue and Bristol Bay areas, this will dramatically drop off the spread.

Senator **Murkowski**. Could we not have a mass inoculation program to try and cut down the number that you anticipate?

Dr. McMahon. Well, one of the problems is we have to screen everybody to see if they are already carrying the virus or if they have recovered, and the reason for that is the vaccine costs $100 to give an adult and $50 to give a child.

Senator Murkowski. That is a small price to pay in relationship to the disease.

Is there not a more effective methodology, since we have an epidemic of people that are going to, as you predict, be infected? Three thousand is a significant number. I just wonder why we cannot use a mass inoculation after an examination, even if it does cost $100 or $50, depending on whether it is a child or an adult? Why are we not doing it?

Dr. McMahon. Well, I think the logistics involved——

Senator Murkowski. Well, we can get help for an epidemic. We do it all over the country.

Dr. McMahon. If we had the money, we could hire the people and do it, but it would involve a large vaccine team because you have to draw blood and then give three shots of vaccine, so that is four visits to each village, which is a considerable amount of effort and time, given weather delays and other things. The other problem is with breakup and freezeup and with summer fishing, you have to time your trips around those events.

Senator Murkowski. I think, Dr. Rabeau, you have a responsibility in this area; is that correct?

Dr. Rabeau. Yes, sir.

Senator Murkowski. Please proceed.

TESTIMONY OF DR. E. STUART RABEAU, DIRECTOR, DIVISION OF PUBLIC HEALTH, DEPARTMENT OF SOCIAL SERVICES

Dr. Rabeau. The answer to that, Senator, is if you give us the money we will go in and do that.

Senator Murkowski. How much money are you going to need to do it?

Dr. Rabeau. It is $100 per adult, it is $50 for each child under the age of 10, to completely go in and immunize the Y–K, the Norton Sound areas, which we know are high.

Senator Murkowski. How much money is it going to cost?

Dr. Rabeau. How about $15 million?

Sure, give us that, we won't bother with screening, we will go in and administer the vaccine to everybody.

Senator Murkowski. Have you asked for it?

Dr. Rabeau. Have we asked for that? No, because we are having a hard enough time getting one-fifteenth of that.

Senator Murkowski. I can not speak for Dr. Rhoades, but it would seem to me that we have an epidemic here and we are not responding in a manner recognizing it as an epidemic. I question the amount of expenditure which seems to be to just continue in a more or less half-committed mode.

I do not know, Doctor, what your observation is as to this being an epidemic, but just to suggest 3,000 people are going to be infected raises the question of why are we not doing something about it? We can get special appropriations for epidemics and disasters, and this is every bit as realistic to me as a natural disaster.

Dr. Rhoades. There are a couple of aspects Senator Murkowski, I think, that are very important, even though they sound like it is an excuse for foot-dragging, and that is that no one really knows whether a vaccine will prevent an epidemic. We know the vaccine is effective in the stimulation of antibodies and in protecting individual people. I think that the approach that has been proposed and has actually been developed under the leadership of Dr. McMahon, the Center for Disease Control, Dr. Rabeau and the State is one that, as they both say, could proceed more rapidly with greater support. Indian Health Service has requested, in our submissions, increased funding for that portion of it, which resulted in a very modest addition of $500,000 to the base, and we also were able to use some of the funds that came very late in the year last year to purchase additional vaccine.

I think it may not be just as simple as immunizing everybody. It is a considerably greater complexity than that. The relationship of the hepatitis B to the complications is the most critical factor, and I think it is fair to say we really do not know the consequences of just immunizing everybody.

Senator Murkowski. Is there any downside to immunizing everybody?

Dr. Rhoades. Oh, yes.

Senator Murkowski. There is?

Dr. Rhoades. Well, I do not know that there is. I think that that question always exists, just like there were 18 cases of paralytic polio associated with widespread polio vaccine, for example. Everything has an adverse effect.

Now, this vaccine is extraordinarily safe, but I think that a deliberate approach, which means doing the screening, identifying the villages—one of the things I believe we do not know also is the degree of spread from Native to non-Native population and so forth.

I think while we are involved in this, we should do those other blood tests and so forth to identify that.

Senator Murkowski. Well, the thing I find totally unacceptable is the reality that we are looking at 3,000 new cases this year and we are worried about how much money we are going to spend. It would seem to me it is a question of how much money we can save by moving now. If you move out now and spend the money and curtail the spread, you are actually saving money in relationship to the $100 and $50 cost of the vaccine if you are going to still increase 3,000 or 2,000 cases a year. I do not understand.

Dr. Rabeau. Well, Senator, it depends on the question of whether or not, for example, there will be 3,000 people that will be infected by hepatitis B in the forthcoming year.

As it stands right now, about 40 percent of the population of the area that is known to be at high risk has been screened and immunization has been started where immunization is called for. You cannot give it to people if you cannot get a hold of them, and as you well know the people on the Kuskokwim and Lower Yukon, for example, are out at fish camps now.

Senator Murkowski. Yes, but they were not out there all winter.

Dr. Rabeau. But, Senator, neither was the money available earlier. This program was started in March, and I would like to point out to you that about 25 percent of the people in the whole area were tested 2 years ago and 1,600 of them were given the vaccine.

Actually, there will not be 3,000 quote, "new cases" or people that will be infected by hepatitis B in this year, because this program is well underway in the high incidence area.

As far as the rest of the State, our figures that are coming in show a very, very low prevalence, and that the communities of people that we thought would be at high risk are showing not to be at high risk. Our latest figures actually work against what we thought was a worst situation as described by Dr. McMahon.

The program is well underway. When fall comes again, we will be able to get into these villages again and continue with the program. As I say, 40 percent of that population has already been covered. I do not, for example, think that 3,000 people are going to be infected by it.

Again, I would like to point out to you that it does not make any difference about the people who get it. The people that carry the virus are the only ones that either get the complications, or get the cancer. I would like to point out to you that our experience throughout the State is that less than 10 percent of the people who get hepatitis B become carriers, and a percentage of those people do not remain carriers over a period of time.

I have very little problem about that with the continued funding that the State is putting up. The Federal Government has asked for $1 million—there's $500,000 in the President's budget for it instead of $1 million. No, we feel if we get that money that we will be able to continue this program and that we will see a very satisfactory resolution of it.

Now, you were looking at what was painted as the worst scenario, and I tell you it is not as bad as it is painted, that we are finding out that it is not quite as severe as we had anticipated. We are running into some very unusual things right in the Y–K area, some of the villages that we have gone out and done.

For example, we did one village where it should have been high; we found that there are absolutely no cases of children under the age of 10 that have have become infected. Now, this was a village that was partially vaccinated and screened in the program a couple of years ago.

We found another village where we found the other extreme: We found that more of the people over 40, had become infected and that only the people in the young age group have it.

I think the program is moving along well, and if you want a candid opinion about how you all can best help us out—make sure that the $1 million that we requested gets into this budget.

The State now has put up roughly $1 million, and proposes over the next 3 years, after this forthcoming year, to put up another $2 million. We have that pledged from the Governor.

Dr. McMahon. I agree with Dr. Rabeau. I think those 3,000 cases would occur if nothing were being done, and if nothing had been done. In the first year or year and a half of the program, the worst scenario would be vaccinating, and that would drop off to, I would say, under a thousand cases a year. So I think that we really just mainly wanted to express our concern about this, and urge your help in getting $1 million, because if we do not get that then we really are going to have to drop off and off, and I think that would be a very bad thing at this point.

Senator **Murkowski**. Well, in the opinion of those who are appropriate to respond on the panel, or Dr. Rhoades—and I will use the word "epidemic" because I think as it represents a percentage of Alaskan Natives that it can be classified as an epidemic—was there an effort to develop a plan of attack that would eradicate, in the shortest possible time, the exposure of other Alaska Native residents coming in contact with the carriers?

Dr. **Rabeau**. Yes. The plan was developed, the plan has been submitted and the program is well underway. Now, circumstances beyond Dr. Rhoades' control for example, is the appropriation from Congress——

Senator **Murkowski**. Well, I do not want to use that as an excuse, because I can tell you right now that your congressional delegation from Alaska, if this is classified by Public Health Service as an epidemic, we can get supplemental funding; no question about it. But it has always been one of those things that, from my perception, was under control. It is not—but there is a need for only $500,000. Is that going to do it or is it not going to do it?

Just to make the record very clear, we obviously have to depend upon the professional requests that come from those that can make the recommendation. If you are looking at $500,000 in addition to the $500,000 you have as doing the job, that is fine, but if it is not going to do the job we ought to know about it and know about it now. We want to know about the severity of the problem so we can resolve it rather than hope it will go away or hope it won't reach 3,000 more people. I am leaving that with you people who are the professionals, and if you mean business come on in and we will do something about it.

Dr. **Rabeau**. Senator Murkowski, you have received letters within the last few months. You received one from the Governor and one from Senator Sackett that explicitly lays out the problems.

Senator **Murkowski**. Yes, but you said you had a program.

Dr. **Rabeau**. That is correct.

Senator **Murkowski**. And you said your program is working, and now you are talking about whether $500,000 is realistic or unrealistic.

Dr. **Rabeau**. No, sir. What we said in the program was that we would need $5½ million over a 4-year period—actually, over the next 3-year period.

Senator **Murkowski**. Why are we talking about a 4-year period? Why do we not go out and crash the program now and save some money by putting it up front?

Dr. **McMahon**. Because, when we do the worst area in the next year and a half, we will really have put the skids on the spread of this virus. I think Dr. Rabeau has indicated that in other areas in Alaska it is not as big of a problem. It is really not an epidemic in the Athabascans and the southeast part of Alaska. It is only an epidemic in the western part of Alaska and these other areas that are going to be hit hard in the first year and a half, I think we will put the skids on the program if we can get the money that we have asked for.

Senator **Murkowski**. Well, you do not treat an epidemic knowing a fishing season is coming up and the people are going to be gone. You get moving on it ahead of time.

People fish for, at the most, 3 months. I am expressing my opinion. Obviously, I am not knowledgeable of the specifics of hepatitis B. I recognize that and apologize for it, but by the same token I would hope, Dr. Rhoades, that we are not sitting on something that we should be moving much, much faster on. There should be requests coming in based on a sound analysis of what the problem consists of and what is going to have to be done to resolve the problem.

Dr. **Rabeau**. Well, we feel that that information is lying there, and we are not talking about a half-million dollars, we are talking about a million and a half dollars, and we are talking about not 1 year but over a several-year period.

This program is going just about as rapidly as it can go. There are some other factors that have to be considered. One is that there is a limitation on the amount of vaccine that is available. This is a unique vaccine.

Senator **Murkowski**. I do not know why we cannot get it and make more.

Dr. **McMahon**. It takes 6 months to make it.

Senator **Murkowski**. That is fine.

Dr. **McMahon**. It is an expensive process; it is a very expensive process, and I do not want to take up your time here talking about it, but we will be happy to furnish you literature that will show you how long it takes, for example, to make it and——

Senator **Murkowski**. What I would ask for the record is that you submit your plan of attack to basically win the war that you are waging and identify what resources you are going to need, and see if we can help you.

Dr. **McMahon**. Yes, sir. We will submit it for the record in detail so that you will have it.[1]

Senator **Murkowski**. I think we have generalized here a little bit, but I do want to move on. I believe Gerry Ivey started this discourse which has been quite valuable.

Who is next?

Dr. **Rabeau**. My recommendations, my paper that I would like to quickly cover, if I could.

Senator **Murkowski**. Go ahead.

Dr. **Rabeau**. Much of the background has been covered in one form or another by a number of previous speakers, but there are nine recommendations that I would like to pass on to you, and one is to start to strengthen the presence and role of the Alaska Native Health Service by restoring some flexibility to their funding. I know it would be nice to get increasing funding, but I also know that it is not feasible, but if they were given the authority to freely move funds from one budget to another without the tedious process that exists at the present time, it would greatly assist them in being able to operate a lot more efficiently.

No. 2. I would like to see the Federal funding to Public Law 86–121 restored—that is the Sanitation Facilities Construction Act—and at the same time I would like to see the State remain involved in the funding, also. Our State funds are being appropriated every year to do some of the sanitation facilities in rural Alaska.

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[1] See appendix, p. 264.

A third thing I would like is—and this is something that you very definitely can help on—is further steps to simplify the utilization of Alaska Native Health Service hospitals by nonbeneficiaries in the rural areas. A start has been made at Bethel, but needs to be opened wider without the stipulation of the private clinic needing to guarantee payment of non-Native hospitalization costs, as is presently the case in Bethel. This makes it impossible, obviously, for a private group to guarantee payment of hospitalization costs of every non-Native that happens to end up in the Bethel hospital.

No. 4. Further and total recognition by the State of its role and the vital necessity for subsidizing primary care in various rural areas for the foreseeable future. We have been over this statement, and my paper develops it. It is a somewhat tenuous but effective network of health care, and there are four sides to it: there is the Alaska Native Health Service; there are the Native Health Corporations; there are the private sectors that are slowly extending out into more of the rural areas; and then there is the State that is best covered by the Department of Environmental Conservation and the Department of Health and Human Services.

No. 5. Increasing and solidifying the position of the community health aide. These individuals are the firstline primary care providers. It is this network of over 200 individuals scattered over the entire State in the nonurban areas who provide the glue that holds the multifaceted rural health service delivery system together.

There are at least six steps to improve their status that should be taken. We need more of them. An increase in numbers is needed, but this function needs to exist in non-Native rural areas as well. We need legal authority to treat them in most rural areas where they, the non-Natives, are a minority.

As it stands at the present time, the community health aides are covered by the Tort Act under the Indian Health Service because of the fact that they are contractees, although it is once removed from them. But to provide medical care to a non-Native out in a rural area, which they have been doing, they are not legally covered, and we need assistance in saying that they are under a legal umbrella.

Two, sharply increase the training. Continued education is a must for these people. The University of Alaska at Fairbanks can provide significant help in this, and they have already started.

Three, increase in financial remuneration, pay and other benefits of these people. They are underpaid and overworked.

Four, better and continuous preceptorship, by physicians and public health nurses.

Five, clear delineation of role, responsibilities, functions, and authorities is needed. Right now, these people operate often in a Never Never Land, that they're really out there on their own without very much in the way of backup or support by either the Alaska Native Health Service or by the State or from the private sector.

And, six, the State needs a definitive policy and continuing finances to strengthen assistance being provided to this program. If the appropriations this year go through as the Senate has put them in, there will be more assistance for training for these people, which has been spoken about by speaker after speaker here.

No. 6 recommends that the National Health Service Corps has recently had some shifts in attitude that reflect adversely on this State. They consider that the Native health corporations should no longer be eligible to receive NHSC professional assignees as they consider these to be operating programs for Natives only; they also apparently no longer feel that subsidization of rural clinics should be done.

And I recommend a reversal of the first policy because the health corporations provide services to all. It is true that the bulk of their service population is Native, but they are not discriminating against the white and other people.

A number of these rural clinics, which are a combination of public, primary and quasi-primary, they'll need subsidization, even partial, at least for the foreseeable future. I think that when we talk about making primary care available throughout the State that we're going to have to make an assumption that in some places they will never become self-supportive and that they will need some type of funding.

No. 7. The State must adopt a policy that funding of these clinics is not a 1-year project, but a continuing effort. Steps must be taken to assist these clinics to reduce subsidization and move toward self-support. Some places will probably also need some financial assistance for many years to come.

No. 8. It is recommended Congress reconsider its recent actions which make it necessary for the IHS to utilize third-party payments, especially medicare and medicaid, to make up large operating deficits. The original 94–437 legislation provided that these collections could be used to assist in maintaining accreditation, and now the appropriations committees have said that replacement of the normal operating budget by these collections is a penalty exacted against the program because the cost of collection must be taken out of program resources, which means there is a penalty exacted against the people. They are not allowed to move some of these funds over to help the clerical staff.

No. 9. Arbitrary, unilateral and quick unpublicized actions such as the reversal of the spouse nonbeneficiary benefits wreaks havoc on State medicaid program plans. This was done suddenly, without advance notice, and had a traumatic effect upon State public assistance program. We recommend consultation and a suitable time lag occur before such precipitous action is taken.

Actually, it is not a very nice way of saying it, but our public assistance people feel that as many as 2,000 people were dumped suddenly upon the medicaid program of this State by an action that was taken in January immediately and effective immediately. We understand fully why it was taken, and we understand the Congress forced them to, and we are requesting the congressional delegation to see if something can't be done to slow down these types of practices.

Senator MURKOWSKI. Thank you very much, Dr. Rabeau, for those constructive recommendations, and I will assure you they will be given every consideration. I assume you have a copy of that to submit.

[The following portion of Dr. Rabeau's prepared testimony was not utilized during his oral presentation:]

Prepared Statement of Dr. E. Stuart Rabeau, Director, Division of Public Health, Department of Health and Social Services

Mr. Chairman and members of the committee, I am Dr. E. Stuart Rabeau, Director of the Division of Public Health, Department of Health and Social Services. I welcome the opportunity to appear at this hearing held at Anchorage, Alaska.

There are several self-evident facts that loom up in any discussion of health care needs and health services delivery in rural Alaska:

(1) The State is huge—distances from rural or bush regions to the few urban areas of Alaska may be incredibly long and area-wise Alaska occupies about ⅕ of the total area of the United States.

(2) Both the climate and terrain can be hostile to humans. The extremes of temperature—as low as the minus forties and fifties, commonplace in the Interior and Northern Coastal areas. Road transportation, except on the Fairbanks-Anchorage axis almost non-existent.

(3) When one speaks of rural and one must distinguish between remote rural (bush) and rural which consists of all communities within the State except Ketchikan, Sitka, Juneau, Anchorage, Fairbanks, and Kodiak, one is basically referring to the indigenous population (Eskimos, Indians and Aleuts) who make up close to 85 percent of the rural (for purposes of this paper I mean remote rural when I use the term rural) population.

(4) There are four different sectors or groups providing care to the rural population:

(a) The Alaska Native Health Service (Indian Health Service) operating a chain of hospitals and clinics in various portions of the State.

(b) The Native Health Corporations—twelve of them covering the entire State providing a wide gamut of health services from community health aides, to clinics and health education to emergency medical services.

(c) The private sector in which there are satellite clinics manned by mid-level professional providers to occasional physicians and small community hospitals in small towns.

(d) The State of Alaska thru the Department of Health and Social Services provides a variety of services extending from a State-wide network of Public Health Nurses, to laboratories performing serology, microbiology and virology tests, to funding of community mental health centers and alcoholism programs and social and welfare services including medical assistance through medicaid.

(5) The political climate is severely tempered by economic factors not just at the Federal level but at the State as well. Fiscal austerity (perhaps not as severe as the Federal level) has become a byword in State operations. The dwindling oil revenues with its concomitant effect on the State Budget has led State programs to experience similar constraints (like the Federal ones). The long range State viewpoint illustrates continued economies and reduction of State governmental activities.

(6) The primary health problems in rural Alaska are those emanating from alcohol abuse and respiratory problems closely associated with the cold and the environment. Accidents and injuries associated with both alcohol excess and rural life rank high in hospitalization causes.

(7) Some of the major health needs fall into the realm of the need for safe water and waste disposal facilities. The extremely cold winters along with permafrost make both distribution of water and disposal of wastes both difficult and expensive.

(8) Lack of roads plus harsh weather makes transportation to secondary and tertiary care sites difficult and costly.

Addressing the needs and problems of the largest provider, the Alaska Native Health Service (ANHS), one finds they are multiple yet can be traced back to a deficiency of financial resources. The extension of PL 94–437, the Indian Health Care Improvement Act is essential if the ANHS is to continue to meet the needs of the Alaskan Natives. The chronic insufficiency of dollars has caused some significant changes in the scope of services provided by the ANHS. This fund shortage has led to underfunding of some of the basic health programs operated by the Native Health Corporations as well as construction of their activities in preventive health. Much of the field health program has, because of lack of funds, been discontinued with retrenchment back into the hospitals and the several clinics operated, in the main, in urban areas. With staff and supplies shortages they are reluctant to provide more than emergency care to the nonbeneficiaries (non-natives) thus compounding the health care needs for the nonnative population.

The Native Health Corporations are primarily funded by either the ANHS or the State. With no increases for inflation or reduction in ANHS contract funds, their programs, primarily preventive, are shrinking if they are unable to get State funds.

The water and waste disposal rural problems were slowly being met by the excellent ANHS sanitation facilities program. Sharp fund reductions badly slowed this program down. However, increased State funding through the Department of Environmental Conservation (DEC) has partly made up for this problem. DEC has wisely made use of the expertise of the ANHS staff through contracts to get some of these projects done. Needless to say the sanitation needs are considerable and will run into the hundreds of millions of dollars to eradicate this problem.

As earlier alluded to when mentioning the rural health care delivery system, it is a complex interrelationship of many diverse elements. At the present time, except for a very few locations, there are rural clinics and hospitals that are stategically located throughout the State. A number of these rural clinics are partially funded by the State through the Division of Public Health. Several clinics are operated as satellites by a private clinic in Fairbanks. One of the large hospitals in Anchorage is working with several more clinics to furnish mid-level providers or locum tenens assistance. Some of the Native Health Corporations are operating or assisting in the operation of some regional rural clinics. Problems still exist; they run the gamut of inadequate physician preceptorship to lack of funds for emergency travel—medical evacuations. Increasing pressure is placed on the State Medicaid program to try to ease this situation.

Alcoholism problems are many, they impact heavily on the rural population. There is very little Federal funding for alcohol programs. With the magnitude of the alcohol and drug abuse problems too little State money is put into this struggle. One program gaining considerable momentum is the village option prohibition which is total in nature and, so far, is having good success. If a village votes dry at a special election no spiritous liquids are allowed in the village irrespective of ownership and whether for sale or personal use.

Furthermore, from a legal viewpoint, there are few organized municipal or borough organizations for a reference point. In many rural portions of the State the best organized entities are the Native Health Corporations and as by intent and primary function they are discriminatory, i.e. they are funded for the purpose of providing various health services to the native population of an area. It requires some changes in organization, functions and operation to provide services equally to the populace, native and non-native. The reverse phenomenon is also, unfortunately, sometimes present wherein the non-native is suspicious or uncomfortable from receiving services from a "native-dominated" group. Accommodations are sought, and obtained, from all parties concerned and one can see steady improvement in what might otherwise be tricky situations.

With the easing of physician shortages and maldistributions in the Southern 48 there is a steady increase of physicians in the State and a slow movement out from the urban areas.

Close coordination and information exchange between the Department and the ANHS minimizes overlapping or double funding of corporations. Program planning and three-way communication between the ANHS, the Native Health Corporations and the DHHS helps to strengthen programming, decrease fragmentation of services and eliminate gaps in delivery of health services in rural areas.

A unique situation has arisen in the State but close coordination between the ANHS and the Division of Public Health (DPH) seems to be solving it satisfactorily. I refer to the Hepatitis B Virus (HBV) control program that is well underway. Thru a memorandum of understanding plus a contract between ANHS and DPH a State-wide program for screening high risk populations and vaccinating susceptibles is well underway. The Yupik Eskimo, living in the lower Yukon-Kuskokwim delta has some of the highest rates in the world for this disease. About half of the funding plus technical consultation is being provided by ANHS. It is estimated that over 60,000 natives and 27,000 high risk non-natives will be screened by this program. Vaccine will be offered to all high risk susceptibles. It is anticipated this program will take 3–4 years to accomplish.

Senator **Murkowski**. I recognize Greg Capito, you may proceed Greg.

STATEMENT OF GREGORY CAPITO, SENIOR PLANNER, VILLAGE SAFE WATER PROGRAM, JUNEAU, ALASKA

Mr. **Capito**. Thank you. First of all, we welcome you back to Alaska Senator, and we would like to extend a welcome to Dr. Rhoades as well. It is not every day that we see this type of assembly gathered here, and we would like to extend our apologies to you both because Gary Hayden can not be here. He had to stay back and guard the nest, but he asked me to prepare a speech for you.

I have prepared a report on rural sanitation in Alaska.

Senator **Murkowski**. Thank you and please proceed.

Mr. **Capito**. Thank you.

As you have heard this morning time and time again, there is a great disparity in our State between urban and rural dwellers. The standard of living and the methods people use to collect water supplies and dispose of sewage are different in our urban and rural communities. This disparity exists, and perhaps is greater than in any other State in the Union.

After doing this kind of work for 8 or 9 years, I am still surprised to go into remote communities and see people hauling rain water off their roof, collecting water from sluice or springs, and disposing of sewage in the age-old method, honey buckets. But it goes on and it continues to go on.

Communities that do have adequate sanitation facilities, again as you have heard earlier, are plagued with extremely difficult problems of operating and maintaining those facilities. This is no small item. It is extremely hard work that costs money and takes time. Also keep in mind that if building and maintaining sanitation facilities were a profit-making proposition, Exxon would have done it a long time ago, and they are not, our small communities have to.

Responsibility for designing and building sanitation facilities in Alaska rests basically with two agencies: the U.S. Public Health Service, which is based here in Anchorage, and the State Village Safe Water program within the Department of Environmental Conservation. That is the outfit I am associated with.

By far, PHS has the larger staff, has built most of the facilities and has been in business since about 1960. Because of PHS, many rural Alaskan villages have at least rudimentary water and sewer service, but for the last several years PHS funding has been tied to HUD housing and that is a serious drawback. What happens to the communities that do not get HUD houses? Well, they are out in the cold.

In contrast, the State has a Small Village Safe Water program. The program consists of a manager, four field engineers and a maintenance person, period. State funding, for your information, has fluctuated radically from $10 million in 1980 to just a few hundred thousand dollars this last year.

With dwindling State oil revenues, the funding picture is just not clear to us. As a matter of fact, it is very uncertain.

Senator **Murkowski**. We have the same problem back in Washington.

Mr. Capito. Now, people have talked about the difficulties of providing sanitation facilities, and there is no denigrating them, but I just wanted to call your attention to one or two improvements that have been made that I think are kind of interesting.

One of the most innovative approaches to providing safe water has occurred along the coastal villages of the Yukon and Kuskokwim Delta, where it is extremely difficult and expensive to obtain potable water. This method of harvesting melt water from tundra ponds just prior to breakup and storing it for later use has proven to be a very simple and relatively inexpensive method of providing safe water when more conventional methods will not work.

By the way, this idea was not a stroke of genius by a college-trained engineer. A Native maintenance man out in Kipnuk had been doing this for years to supply the BIA school there. A smart engineer took advantage of this gentleman's idea, incorporated and now Kipnuk has a safe water supply.

Another bright spot in the field of rural sanitation that I want to share is the relationship that has evolved between the Federal and State programs. The coordination is excellent. It is ongoing and it is continuous, and I think the reason is that both sides realize the immensity of the job, realize that the resources are limited, and only by pooling their resources can they ever hope to change things around.

But the coordination, I think, is a model for other Federal-State agencies to follow, the coordination between PHS and the State.

The current status of sanitation facilities in Alaska makes it extremely difficult to summarize, but one must wonder with the collective energies of two agencies focused exclusively on providing sanitation facilities, why hasn't the problem been solved? Why is Alaska decades behind our rural counterparts in Iowa, Nebraska, and Wyoming?

There are several reasons. The first of these is called the "generation gap". When going into remote villages, systems are usually installed in phases. First comes a watering point, and subsequent years a laundromat, and in later years perhaps a piped water and sewer system, so it can take a full generation to bring a community up to an adequate sanitation level. You cannot do it overnight, certainly.

Second, I have found that we have got to build and rebuild systems. The Arctic environment is a tough nut to crack. Permafrost exists in very few locations in the Southern States. If you put a building up, and you don' t have a good foundation, you are in big trouble. You are going to have to rebuild that facility.

Third, operation and maintenance is the single biggest problem, I think, in the field of rural sanitation. How do small communities with no tax base maintain water and sewer facilities? No one has come up with an answer yet. It's a tough nut to crack.

I have some recommendations that I would like to wind up my presentation with that will hopefully help out here.

The first recommendation is to stabilize PHS sanitation facility construction funding in Alaska so that meaningful planning for capital improvements can be done. Funding should be allocated in such a way that communities without new housing are served as well as those that obtain new housing.

Second, provide PHS with an annual $1 million emergency fund to permit more expeditious, and therefore less costly, repair of broken facilities. This is a way of protecting the Federal Government's capital investment. If you run out and repair a facility quickly, you may not have to rebuild it.

Third, increase Federal revenue sharing to small communities to help them defray the cost of operating and maintaining sanitation facilities. Revenue sharing is an existing mechanism; let us make it work for the small communities.

Fourth, restore CETA funds to allow remote communities to hire water and sewer plant operators. In six Kodiak Island villages, water and sewer plant operators are going to be fired October 1, 1983, because there is going to be no bucks. Those facilities will probably go down the tubes as a result.

Finally, make a research grant to PHS to study methods of collecting and disposing of human waste in remote villages. This investigation should focus on innovative methods that are inexpensive to build and maintain.

Obviously, the technology exists now to collect and dispose of sewage; that is easy. How do you do it in a remote community and enable that community to operate and maintain that system? That is the difficult part.

There has got to be a way to solve the problem with waste water disposal in the bush, and that method has to take into consideration the capabilities and economic situations of those residents. That is one of the unsolved problems in the bush.

Senator MURKOWSKI. The Eskimo that you indicated had found a way to take water out of the pothole and make it potable did not come up with the answer to that one, did he?

Mr. CAPITO. He has not yet.

Senator MURKOWSKI. Not that we know of. Perhaps we should go back and ask him.

Mr. CAPITO. Thank you for the opportunity to share, briefly, the State's perspective with one closing thought: The State has a small program and we are struggling, but one of the things that we are finding out is that we have excellent cooperation in the regional health corporations here in helping us set construction priorities. They have been doing this for several years. When these people come to you for help, please keep in mind that they have got an excellent track record here. They have helped the State immensely in trying to discern where the problems are, and we have had great success in working with those people, particularly those 12 health corporations. They are to be commended for doing a difficult job that, frankly, no one else is capable of doing out in the bush areas.

[The prepared statement follows:]

PREPARED STATEMENT OF GREGORY CAPITO, SENIOR PLANNER, VILLAGE SAFE WATER PROGRAM, JUNEAU, ALASKA

THE SETTING

Sixty four percent (64%) of Alaska's resident population live in cities such as Anchorage, Fairbanks, Juneau and Ketchikan. These communities have the amenities of cities in the lower 48 states. But beyond the bright light and bustling urban centers there's another Alaska that few residents or vistors will ever see. This "other Alaska" is characterized by 220 isolated villages with populations between 25 and 600 people. Only a few are connected by a road system, and access is limited to boat or airplane. In 98 communities, telephone communication is a single village phone. Fuel and general supplies are delivered by barge each year between June and mid-September.

Most villages lack a tax base and residents subsist by hunting, fishing and trapping. Seasonal employment consists of commercial fishing, construction work and fire fighting. Communities may be governed by elected officials or by a traditional council. Full- or part-time employees handle the day-to-day affairs of the village but few are supported by public works departments. Other institutions include schools, a store or two, and a public health clinic.

As civilization moves into Alaska's hinterlands, the needs and desires of the State's rural population for improved sanitation services have increased dramatically. Building and maintaining these services in the harsh arctic and subarctic environment is difficult, time consuming, and expensive.

DESCRIPTION OF PROBLEM

There is a great disparity in Alaska between urban and rural dwellers. This difference in lifestyle and standard of living is greater than in any other state. For example, thousands of urban Alaskans, like their counterparts in the lower states, take safe water and hygienic sewage disposal facilities for granted. Piped water and sewer service to each home is the accepted standard. But a first time vistor to a remote Alaskan village is struck by the fact that many bush residents still haul water from a river, community well or spring, dispose of their wastes in honey buckets or outhouses and dump their trash in an open pit. These methods were eliminated in most cities and towns of the lower states by the early 1900's, but persist today in many remote Alaskan villages.

While accurate statistics are lacking, it is estimated that at least 30 villages do not have a protected safe water supply. Another 50 or 60 haul water from a single village well. Relatively few have piped water and sewer in their homes or any provision for washing clothes or bathing.

The communities that do have adequate sanitation facilities are plagued with the difficult problems associated wtih operating and maintaining these services. Maintenance costs often exceed revenues and as a result, many village owned water and sewer systems operate at a deficit.

EXISTING PROGRAMS

Responsibility for designing and building sanitation facilities in rural Alaska is shared by the federal government in the form of U.S. Public Health Service (PHS) and the State Village Safe Water (VSW) Program within the Alaska Department of Environmental Conservation.

By far PHS has the larger staff, has built most of the facilities, and is the better recognized of the two having been in business since about 1960. Because of PHS, many Alaska villages have rudimentary water and sewer service. For the last several years, PHS funds have been limited to serving villages that are in line for HUD housing projects.

In contrast, the state has a small Village Safe Water Program to assist remote villages with design and construction of sanitation facilities. The program started in 1972 was modeled after the Alaska Village Demonstration Project (AVDP) in Section 113 of the Clean Water Act. The program consists of a manager, four (4) field engineers and a maintenance person. State funding has fluctuated dramatically over the years from a high of 10,000,000 in 1980 to a few hundred thousand in 1982. With dwindling oil revenue future funding is uncertain. The state effort has resulted in improvements in about 50 villages. As the attached fact sheet indicates, state funds are not tied to housing projects and, unlike PHS, VSW can build facilities in native and non-native communities.

These federal and state programs have spent about $190 million in the last 20 years to improve village sanitation facilities.

SYSTEMS THAT WORK

Improvements have been made in the methods rural Alaskans use to obtain water and dispose of sewage. Projects that have stood the test of time are characterized by careful planning and straightforward engineering design, coupled with sound Arctic construction practices and direct local involvement at each step in the process.

Some of the most innovative work has taken place in coastal villages of far western Alaska, where potable water supplies are extremely difficult and expensive to develop. Fo rexample, harvesting melt water from tundra ponds, just prior to breakup, and storing it for later use, has proven to be a simple and cost effective method of providing safe water when more cnoventional methods won't work.

COORDINATION

Another bright spot in the field of rural sanitation is the close working relationship that has evolved between these federal and state programs. Managers from each agency are in almost daily contact so there has been no duplication of effort or redunancy in providing sanitation facilities. Examples of this ongoing cooperation follow:

(1) There has been a joint effort to develop and publish an Inventory of Sanitation Facilities in over 200 remote villages. This publication is updated annually and the Alaska Congressional delegation has the latest version.

(2) State priorities for new VSW facilities are established by a technical board, one member of which is a design engineer recruited from PHS staff.

(3) A top PHS program manager has testified before the Alaska Legislature's Community and Regional Affairs Committee (via the State teleconference network) on the need for improved sanitation facilities in specific villages.

(4) Joint PHS/VSW construction projects have been undertaken and now occur with such frequency, that they are considered routine.

(5) Technical assistance by PHS for the State's new Remote Maintenance Worker pilot program has resulted in better operated sanitation facilities along the Lower Yukon River.

Keep in mind that this cooperation has been going on for years without the mind boggling array of agreements, MOU's and forms one might expect. Rather, both organizations realize the immensity of the job and recognize that neither side has the resources to accomplish this task alone. Consequently, extremely effective cooperation has resulted.

CURRENT STATUS

With so much money already spent and the collective energies of two agencies focused exclusively on closing the gap between urban and rural dwellers, why hasn't the problem been solved? Several reasons are discussed below:

1. Generation gap

Village sanitation facilities are usually built in phases, that is, a watering point is built first, followed by a haul system or laundromat in subsequent years, and if conditions permit, a piped system is constructed when the community is able to handle it. Consequently, upgrading service to acceptable levels may take a generation or more. This experience is not unlike frontier America which took several decades to develop. Keep in mind that sanitation facility construction in Alaska is only 20 years old.

2. Build and Rebuild

Given the harsh physical environment of Alaska's arctic and subarctic regions, vilage sanitation facilities that have been built usually need renovation after several years and in some cases must be completely rebuilt. Frozen and broken water mains, buildings that suffer from jacking due to ice rich soils, leaking water storage tanks, and water sources that freeze or dry up are part of the problem of doing business in the far north. Add to this, outdated and undersized facilities that need expansion to handle growing populations and one gets the feeling that the current construction effort is not keeping pace with the increased demand for services. In fact, it has been estimated that current unmet needs in rural Alaska total $200 million.

3. Operation and Maintenance

Facilities that are not properly maintained fall into disrepair and need to be rebuilt. Given the rate of inflation and the high cost of building in the north, the toll in terms of time and money can be staggering. For example, a community washeteria built in 1979 cost about $650,000. Today that same facility costs upwards of $1.3 million and the project could take two to three years to complete given the difficult logistical problems involved and the vagaries of obtaining funds. During this "waiting" period, the village usually reverts back to primitive methods of collecting rain water or hauling ice.

In summary, constructing new facilities, renovating or expanding existing ones and rebuilding systems that are in a state of disrepair requires a tremendous amount of time, money and effort. As a result, remote Alaska villages are decades behind rural communities in the lower states.

RECOMMENDATIONS

In order to close this gap and improve sanitation facilities in Alaska's remote villages, the following recommendations are made:

1. Stabilize PHS sanitation facility construction funding in Alaska so that meaningful planning for capital improvements can be done.
2. Provide PHS with an annual $1,000,000 emergency fund to permit more expeditious and therefore less costly repair of broken facilities.
3. Increase federal revenue sharing to small communities to help them defray the cost of operating and maintaining sanitation facilities.
4. Restore CETA funds to allow remote communities to hire qualified water and sewer plant operators. (Water and sewer plant operators in 6 Kodiak Island villages will be fired October 1, 1983 because of funding cutbacks.)
5. Make a research grant to PHS to study methods of collecting and disposing of human waste in remote villages. This investigation should focus on innovative methods that are inexpensive to build and maintain.

Thank you for the opportunity to explain the State's perspective on Alaska's rather unique situation.

VILLAGE SAFE WATER (VSW) PROGRAM

Nature and purpose of program: Provide for safer water and hygienic sewage disposal facilities in remote Alaskan villages.

Who may apply: Any incorporated community which has between twenty-five and six hundred people residing within a two mile radius, or a second class city may qualify. First class cities are excluded by statute from participating in the program.

Authorizing legislation: As 46.07.

Administrative agency: Alaska Department of Environmental Conservation.

Type of assistance: 100 percent of the cost of designing and building sanitation facilities is provided through grants to communities. No local match is required. VSW staff provides technical and administrative support to a community during planning, design, and construction of the project.

How program is financed: State bonds are sold to provide a fund which can be used for design and construction of facilities. Also, appropriations authorized by the Legislature for specific communities are used to fund projects. Funding sources in the last five years include: Chapter 145, SLA 1978; Chapter 97, SLA 1980; Chapter 88, SLA 1981; Chapter 25, SLA 1982; and Chapter 101, SLA 1982.

The amount of funding varies dramatically from year to year. For example, $10 million was received in 1980 but less than $500,000 was received in 1982.

Program history: The VSW Act was passed in 1972 and was intended to help small, remote Alaskan communities improve sanitation facilities. To date, improvements have been made in about 50 villages. The cost of projects has ranged from $50,000 to $1 million. The staff consists of a program manager, a planner, four field engineers and a maintenance specialist.

How to apply: Consistent with CSHCR # 110 (1976) construction priorities are determined by the Department working in concert with twelve Native Regional Health Corporations. Once established, the priority is included in the Governor's capital budget request for funding.

For more information contact: Greg Capito, Village Safe Water, Department of Environmental Conservation, Pouch 0, Juneau, AK 99811; Phone: 465-2664.

Senator **MURKOWSKI**. Thank you very much for your testimony. I want to thank you. I think we have had a good amount of testimony and had a spirited discussion on hepatitis B. We will go back and reflect a little bit on what, if anything, we should be doing to accelerate, the combating of that disease.

Doctor, do you have anything to add before I conclude the hearing?

Dr. RHOADES. I appreciate very much the opportunity to make a final remark, Senator.

Thank you once again for the opportunity of permitting me to find myself in the unusual, but very rewarding, situation of sitting here. I had told Pat Zell that I was honored and flattered to be asked to attend with you, and I assume that part of the deal would be if I sat here I could ask questions for awhile instead of answering, but I think the answers were present.

If I might perhaps just strain protocol, I would like for you to permit me to introduce Lillie McGarvey, who I believe has not been introduced, and who is in the audience. She just may have been the first community health aide. I know she worked in her own village without pay as a community health worker some years ago, and I had the privilege of working with her about 10 years ago.

Now, with that apology, I will conclude my remarks, but I appreciate her attending today.

Senator MURKOWSKI. Lillie, please stand up and be recognized.

Dr. RHOADES. Senator, I would like for you to know that as director of Indian Health Service, I have made notes, I have listened carefully to the excellent recommendations and some of the exciting possibilities for the future that I take seriously and will give study to. This afternoon, I will spend most of the afternoon with Dr. McMahon on the hepatitis B. I am taking that as a personal part of my responsibility as director. It happens to be my professional background. Although I do not know that much about hepatitis B, it is written into my work plan for the coming year and I will be visiting with Dr. McMahon, as I said, exploring further all the entirely appropriate questions that you raised. I will also take the opportunity to visit some of the other communities in Alaska which I propose to do over the coming year.

And then finally in closing, I would like to salute, not only the regional health corporations who have, I think, pioneered in health delivery, but the community health aides as colleagues of mine in delivering health care. I am flattered to share with them a program like this. This chapter of medical care is really heroic in this country and I am sure it will be regarded as such for many, many years in the future. I take my hat off to that group of people, and I appreciate the opportunity to share some time with you.

Senator MURKOWSKI Thank you very much, Doctor. I think that the hearing has been meaningful. The witnesses have been outstanding, and I want to compliment all of you who have persevered a good portion of the morning. We have been fortunate to have you with us, Dr. Rhoades, because as director of the Indian Health Service you direct, the agency responsible for carrying out the health services. I think that you have seen and heard in testimony from the witnesses, a tremendous dedication and commitment to the Native people in Alaska. As a consequence of this hearing and this testimony, I think that we can go back and relate more specifically to the recommendations made and provide a more meaningful and responsive service.

I want to thank our reporter, Marianne. I want to thank everyone who has participated in making this possible.

I would again remind you that the record will remain open for a 2-week period. If there is anything that anybody wants to submit, any written testimony or comment, it will be included in the record.

I want to thank all of you again for participating. We have shared many views this morning, and as a consequence of sharing that knowledge we have a better understanding of the necessity of resolving many of the concerns that were expressed. I think that we would all agree that considerable progress has been made over a period of time but that there is a lot of room for future improvement. That is why we are here this morning.

I will conclude this hearing of the Select Committee on Indian Affairs, and again thank you all and wish you a very pleasant day and a pleasant summer.

[Whereupon, the hearing was concluded at 12:25 p.m.]

APPENDIX

Additional Material Submitted for the Record

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

BILL SHEFFIELD, GOVERNOR

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JUNEAU, ALASKA 99811
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(907)465-3355

June 2, 1983

The Honorable Frank Murkowski
Senator
United States Senate
317 Hart Building
Washington, D.C. 20510

Dear Senator Murkowski:

Commissioner Robert London Smith has asked that I provide comments for your consideration for presentation during Senator Murkowski's meeting on Indian Health Service budget concerns scheduled for January 3 in Anchorage:

1. Transportation Policy: The Indian Health Service has elected to delete medically necessary transportation as a covered service in rural Alaska for Alaska Natives. This has caused a tremendous burden to be placed on local communities and individual Alaska Natives, particularly those who are non-welfare eligible and are not able to secure the needed medical travel from the Alaska Department of Health and Social Services through other State programs. Concurrent with this Indian Health Service policy change, the Bureau of Indian Affairs General Assistance Program was terminated which also removed $8 to $9 million in direct cash payments annually from rural Alaska which could have helped meet this need. Local village governments are finding it increasingly difficult to meet this ongoing need for rural Alaskans. The Indian Health Service should provide the same level of service to Alaska Natives as enjoyed by those persons served by Indian Health Service agencies in other states.

2. Lack of Written Agreements between IHS and State of Alaska: Since 1972, the State of Alaska and Indian Health Service had reached an annual agreement on the scope of services to be provided by both agencies to serve Alaska Natives. The Department of Health and Social Services has been unable to consummate an agreement with the Indian Health Service for the last two years because of the uncertain federal budget picture and the Indian Health Service Alaska's inability to commit itself to a long term agreement. If the State of Alaska is to insure that adequate medical services are available to Alaska Natives in rural areas, it is critical that the State have assurance from the Indian Health Service as to the minimum medical services that will be offered throughout Alaska to

rural Alaska natives. It is impossible to plan a meaningful, effective medical delivery program for rural Alaskans without this cooperative understanding between the State and federal government. As funding difficulties continue to worsen within the Indian Health Service budget, and positions become vacant throughout the State, individual medical specialties will certainly disappear from the Indian Health Service hospitals causing the range of medical services to differ from one service area to another.

3. Lack of Coordination Between IHS and Medicaid: Both the Indian Health Services and the federal Medicaid Programs are retreating from historical financial responsibilities in the State of Alaska and are thereby reducing their share of expenses incurred to provide medical services to Alaskans. There appears to be no coordination between the Indian Health Service and the Medicaid agency in determing these policy changes. As Indian Health Service policies reduce the scope of coverages on the one hand, and Medicaid reimbursement rules reduce the level of federal funding available to the State to support the increased responsibilities on the other, the effect will be quite severe in the long term.

4. Potential of Medicaid CAP: With the increased financial responsibilities assumed by the Alaska Medicaid Program, coupled with the uncertainty of federal financial participation for fiscal years 85 and beyond, the State of Alaska is extremely concerned that introduction of a Medicaid CAP or Block Grant by Congress would leave the State with an expectation that cannot be supported by available State funds. It is critical that federal officials understand the significance that a CAP or Block Grant would have on the State of Alaska, as a result of the concurrent IHS and Medicaid reductions over the last few years. Any legislation that would impose such a CAP or Block Grant on Alaska should provide clear discretion for the State to divert available federal funds first to indigent Alaskans, Native and Non-Native, before requiring the obligation of federal funds to the Indian Health Service to support activities in their facilities. Where Medicaid funds are not used by IHS for operational purposes but rather for capital improvements, priority should be given to spending funds for direct service delivery purchased through non-IHS medical providers in Alaska.

Sincerely,

Rod Betit

Rod Betit
Director

cc: Commissioner R.L. Smith, Ph.D.

ALASKA NATIVE COMMISSION
ON ALCOHOLISM AND DRUG ABUSE

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Introduction

With a diverse range of ecosystems over thousands of years, the Native peoples of Alaska have developed their own distinctive cultural adaptations. It should be noted that "Alaska Native" is an administrative term which tends to obscure the fact that Alaska Natives - Tlingits, Athabascans, Haidas, Eskimos, Tsimshians, and Aleuts (TAHETA) - are historically, linguistically, and culturally distinct and have traditionally adapted to life in natural environments which differ from that of American Indians, generally. TAHETA peoples, for instance, have never been subjected to the experience of living on reservations, but instead have continued for the most part, to occupy their traditional lands. In recent years, PL 92.203 "Alaska Native Claims Settlement Act of 1971" and the related formation of the regional Native corporations have made Alaska Natives a significant collective force in the State of Alaska from the economic and political standpoint.

As inferred above, the experience of acculturative pressure is different from the overall American Indian experience in that it is of a shorter duration and qualitatively different. It has, however, been very intense, especially in recent decades. In the last 100 years, Alaska Natives have moved from a full-time subsistence hunting and fishing mode of life to part-time participation in the wage economy. This transition has been a result of depletion of game resources, larger families, universal educators' conversion by various missionaries and an increasing demand for goods and services. These are but a few of the many and complex factors involved in this process. The old nomadic way of life has been greatly attenuated. Natives today tend to live in fixed settlements. The majority (60%) live in rural native villages. These are isolated rural places, in which the native languages tend to be spoken and an economy oriented towards subsistence hunting and fishing, along with part-time or seasonal participation in the cash economy. Another 13% live in predominantly rural native villages. The villages contain few white minorities. English is the main language spoken and there is a greater emphasis on the cash economy. Twenty-two percent of Alaska Natives reside in cities, such as Anchorage, Fairbanks, Juneau, Sitka, Kodiak, and Ketchikan.

Various estimates as to the size of the Alaska Native population at time of contact (1740-1790) place it at approximately 74,000 (Rogers, 1971). At the time of its first formal enumeration in the 1880 census, the Native population was found to be 32,977. The population continued to decline, mainly due to epidemics of infectious diseases, until about 1910-1915. It was not until 1947 that the 1880 figure was reattained. During the period 1940-1970, heavy immigration into Alaska resulted in a six-fold increase in the non-Native population. Therefore, in the 1940s, Native population passed permanently from a position of numerical equality to minority status. Recent calculations (Buffler and Knaus, 1978) show that in 1974 there were 58,028 Alaskan Natives. Of those, 24,752 (47.6%) were southwestern Eskimo (Yupik); 11,983 (20.6%) were northwestern Eskimo (Inupiat); 10,729 (18.4%) were Tlingit-Haida-Tsimshian; 7,695 (13.2%) were Athabascan, and 2,869 (4.9%) were Aleut. This shows the traditional distribution of the Alaska Native people.

It is clear, therefore, that the patterning of alcohol abuse and misuse and the delivery of alcoholism services in rural Alaska is complicated by a variety of factors that render the application of concepts and models developed elsewhere to be difficult. Distance, which adds enormously to expenses of travel; isolation, due to geographical inaccessibility and the variances of the weather; problems of communications via radio; wide regional differences in perceived needs, and cultural diversity are only some of the factors which must be taken into account in planning and developing programs that are culturally and socially acceptable for rural villages.

The Native Corporations

The year 1971, which marked the passage by Congress of the Alaska Native Claims Settlement Act, was a year of crucial importance in the long history of the Alaskan Native people. After more than a century of effort, the Native people, by virtue of the settlement, gained title to large areas of their aboriginal lands and payment on lands in the form of cash for a total of almost one billion dollars. Thus, in the 1970s, we find superimposed on the ancient cultural distributions and traditions outlined above, a western corporate business structure. The regional Native corporations have had and will continue to have a very great effect on the Native way of life and have been instrumental in moving the Alaska Native people into the center of Alaska's economic and political life. Each regional Native corporation includes a non-profit component, one of whose functions is the establishment of a regional health corporation. Through one regional health corporation, our Native people began to address themselves to their long-standing health and alcoholism problems. Regional health corporations are, therefore, elements of crucial importance in the planning, development, and implementation of alcohol and drug abuse programs for rural Alaskan Natives in all areas of Alaska, but especially in areas of rural Alaska where the Native health corporation may be the only resource. It is worth noting that only 19 of the 209 villages incorporated under the Settlement Act are accessible by road. By 1975, 16 rural villages had no communications with the outside world. The corporation boundaries, for the most part, conform to the cultural boundaries. It will be noted that the current total figure for Alaskan Natives officially enrolled as corporate members by the Alaska Native Enrollment Office of BIA is 74,433. (These figures do not include births after 1971). This discrepancy is due to the fact that a sizable number of Alaskan Natives eligible for enrollment, because of partial Native ancestry will not be identified in the formal census procedures from which standard population figures are derived.

Alcoholism: The Historical Dimension

Just as in all other cultures of the world, the disease of alcoholism has not always been a part of the Native lifestyle. The earliest explorers in the Arctic noted that there was no presence of any type of alcohol among the rural Natives of Alaska, but remarked the kindness and compassion with which they were treated in comparison with the abysmal standards of care, then prevalent in the western world.

Unlike certain other Native American cultures, Alaskan Natives had no experience with alcohol prior to contact. Starting with the importation of Vodka by the Russians and continuing through the eras of the fur traders, whalers and miners, to the large military presence in World War II, the flow of alcohol into Alaska has steadily increased in rural villages. The years since World War II have seen a particularly rapid increase in availability and consumption. As with nomadic hunting and fishing cultures all over the world, alcohol has had a catastrophic effect on rural and urban Alaskan Natives alike.

Most authorities agree that none of the Alaskan Natives knew distilled alcoholic drinks prior to the arrival of the Europeans in the 16th and 17th centuries. In Alaska, it was as recent as the 19th and 20th centuries.

The TAHETAs - that is the Tlingit, Athabascan, Haida, Eskimo, Tsimshian, and Aleut - of the State of Alaska, were therefore quite unprepared to deal with the distilled beverages, which the early explorers and traders commonly offered them as a sign of friendship. It is not surprising that some declined to drink, some spat it out in disgust and others accepted it and drank to the point of intoxication. Alcohol was credited with supernatural powers among certain tribes in the 18th and 19th centuries,because it released inhabitions, dulled pain, and at the extreme, induced oblivion; the same reasons many people find alcohol helpful today.

Social/Cultural Family Life Among Alaskan Natives

Alaskan Native people belong to a cultural sociological group which utilizes the extended family system. This system not only recognized father-mother, sister-brother relationships, but any and all individuals from generations past which may have a particular relationship to that family; for example, fourth or fifth cousins, aunts, uncles, and/or any person who may have any direct or indirect relationships to the family. This may even be distant blood relatives and/or relationships through past generation marriages. Relatives are further defined as first and second cousins, aunts, uncles, etc., and relations are anyone that is a third counsin or further back, or anyone who may have married into the family from prior generations.

Another aspect to the family relationship not normally considered by the majority cultures, is that of a religious family which is comprised of individuals who may or may not be related to one another, but still may comprise a religious family unit as a mother, father, sister, and brother. These individuals are, in many cases, considered relevant and respected as the blood parents of the children in such a family.

Alcohol/Drug Abuse in Alaskan Natives - Overview

The current difficulties of Alaska Natives can only be understood against the background of the traditional cultures. Each individual lived his life within a timeless, consistent, and supportive organization of human associations. The intimate traditional associations centering on family, kin, faith, and locality and the small, tightly-woven network of informal personal relationships which formed the basis for social, religious, economic, and political order, were the organizing principles of life and were a source of support that could always be relied upon. As an Alaskan Native describes it: "I love to go home to my village because I know that each person, in their heart, is holding hands with all the others all the time."

This testimony addresses itself to only one aspect of the shattering impact on the traditional ways of life through the process of acculturation, which has been excruciating in its speed and intensity. For many Alaska Natives, and especially for the young, the breakdown of the organized, consistent, traditional relationships due to pressures from without has resulted in a reduced ability to find and hold a position of psychological integrity and continuity. Loneliness, anxiety, frustration, continuing stress, and at times, despair, characterizes the lives of many Alaskan Natives today. In the western medieval system, these people came to be called fourth avenuers, alcoholics, skid-rod, drunks, etc.

Patterns and Extent of Alaska Native Drinking

In one central region in the State of Alaska, 70% of the population over the age of 15 reported that they drank. This number included 82% of the men and 55% of the women. In the age group 20-29, 99% of the men and 72% of the women are drinkers, whereas in the age group 30-39, the figures were 93% and 85% respectively. After 40, there is a marked decline for the men.

In the 15-17 age group, 50% reported drinking; 60% of the boys and 40% of the girls. Drinking began between ages 9 and 17, with an average of 15½. Of those under 17, 88% reported that most of their friends drank. Thirty-one percent of the total were abstainers, 45% less often then 3 times a week and 24% drank three or more times a week. Evidence was presented to show that both sexes, but especially the women, were drinking more in this 1980 generation than in the last.

In another region, it was reported by SOADA that 70% of the crimes in that region were alcohol-related. In Anchorage, there were 750 arrests per month for DWIs, 90% of which were Alaska Natives.

Summary

Alcoholism is one of the most serious health problems facing the Alaska Native people today. This fact is now clearly recognized by rural villages, regional hub centers, AFN and ANCADA, along with other statewide resources.

Historically, alcohol was introduced into most Native cultures from the outside and among a people who held no traditional way of coping with it. The effects on health, family relationships, and traditional society were profound and in some cases, disastrous. Partly due to the efforts of the rural Alaska Natives themselves, the federal government banned the sale of alcoholic drinks to Alaska Natives/American Indians from 1802 to 1953 - although liquor always found its way, with the help of bootleggers, to those who wanted it. Since 1953, the sale of liquor to Alaska Natives has been a local tribal matter and the State of Alaska has a Local Option Law, which is poorly written.

The adverse affects of alcoholism in the Alaska Native population today are generally felt to be considerable, but valid information is scarce. Special surveys have documented that the prevalence of drinking is high in many rural communities, that drinking is primarily a social activity, and that intoxication is the common, but by no means inevitable outcome. Probably a majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infections, cirrhosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments of Alaskan Natives are for drinking or are the results of drinking. The associated loss of productivity and the resulting abnormal social adjustments are by-products of considerable importance.

Like most Americans, Alaskan Natives usually have mixed feelings about their relationship to alcohol. Drinking to excess is not condemned, but neither is it criticized by many Alaskan Natives, so long as no harm is done to others. Many others feel that alcohol should be entirely banned for sale or distribution in rural Alaska Native communities.

Alcoholism in Alaska Natives has, in general, many underlying causes. It is a means of coping with feelings of anger, frustration, guilt, fear, or boredom, all of which are related to the position in which many Alaskan Natives find themselves today. Inferior feelings about their lack of education, meaningful employment, status and economic autonomy, which are characteristic of many Alaska Native groups, are expressed in excessive drinking. These features of modern Alaska Native life, particularly affect the adult men and adolescents of both sexes. The latter group are further faced with unique problems in both the home and school environment, such as the break-up of family relationships (often due to drinking) and the disparagement in the schools of their parents' way of life.

Alcoholism, therefore, is a problem which deserves the best efforts of the ANCADA staff working not alone, but in conjunction with other regional and rural village agencies or groups who are concerned, and especially with the Alaskan Native people themselves, who are more than ever, recognizant of the urgency of the situation.

Daisy May Lamont
Daisy May Lamont
ANCADA Executive Director

Alaska Native Health Board

1689 C STREET, SUITE 230, ANCHORAGE, ALASKA 99501 PHONE (907) 276-8989

Reference #A83-0608

June 8, 1983

Ms. Patricia Zell
Senate Select Committee on Indian Affairs
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Ms. Zell:

Enclosed you will find four documents being submitted as written testimony invited during the course of the Senate Select Committee IHS Hearings held in Anchorage, Alaska on June 3, 1983. We ask that this information be included as a part of the record for those proceedings.

Please note that copies of the two documents prepared by the Yukon Kuskokwim Health Corporation may have already been submitted for the record. Copies are being to insure they are included as a part of the permanent record.

Sincerely,

Bonnie Gabaldon

Bonnie Gabaldon
Administrative Assistant

BG:km
Enclosure

Alaska Native Health Board

1689 C STREET, SUITE 230, ANCHORAGE, ALASKA 99501 PHONE (907) 276 8989

June 3, 1983

The Honorable Frank Murkowski
Senate Select Committee on Indian Affairs

Dear Senator Murkowski:

We appreciate Congress' efforts to help the Native Americans bring their standard of living up to par with the rest of our great Nation. You have done this with various laws, including P.L. 93-638, P.L. 94-437 and others.

We also appreciate your assistance when we must fight with the bureaucracies when they create regulations, policies and guidelines which serve to circumvent the intent of the law.

But, I feel that we must object vigorously to the fact that our time allotted for our testimony was cut to 1/4 what we were promised. This is the first time, in 8-1/2 years of my being on Health Boards, that we have had an opportunity to offer testimony on our home grounds.

We support the reauthorization of P.L. 94-437. We would appreciate the Senate and House putting some meat on the bones of 437.

Congress gave us an opportunity to greatly improve our Health Care Delivery System, our water and sewer systems, and educate some of our people in the health or related fields.

A question must be asked here, and that is, "Who runs the Federal Government of the U.S.of A.? Our House and Senate, the Congress of the U.S.of A., or the President and his appointed bureaucrats?"

Because this question has to be raised, I feel that we must recommend that P.L. 94-437 be reauthorized and that Congress actively participate with the Indian Health Service and the Tribes of all Indian nations to develop new regulations to insure that the intent of the law is complied with. Also, the President and Office of Management and Budget must have their budget cutting teeth pulled to insure that the authorized monies to improve our Health Care Delivery System and water and sewer projects and completed and are indeed appropriate.

Again, thank you for your consideration and deliberation.

Sincerely,

Darryl Trigg BG

Darryl Trigg
Treasurer
ALASKA NATIVE HEALTH BOARD & NORTON SOUND HEALTH CORPORATION

DT:bg

ALASKA
Health Education
Consortium

Box 581
Anchorage, Alaska 99510

June 1, 1983

The Honorable Frank Murkowski
Chairman
Senate Select Committee on Indian Affairs

Dear Senator Murkowski:

The Health Education Consortium (A.H.E.C.) is composed of professional individuals involved in the promotion of health education throughout the State. A nonprofit group, our members represent a broad cross-section of interests from federal, state and local governments; Native Health Corporations; regional health agencies; school districts; and community-based health care facilities.

As advocates of health, the Alaska Health Education Consortium wishes to commend and thank you for your past and present support in the U.S. Congress on the Senate Select Committee on Indian Affairs.

As a group of Health Educators, we have recognized the apparent need for continued health care delivery services to Alaskan Natives. Public Law 94-437, the Indian Health Care Improvement Act provided great potential for helping to overcome long-standing health problems of Alaskan Natives. However, the Alaskan Native health status both in quantity and quality is far from sufficient in several areas of need. Contributing to this is the difficulty in the communication and transportation systems, and for Alaska, severe climatic conditions. Delivery of health care services is still presents challenges unique to Alaska.

The Alaska Health Education Consortium supports the continued and reauthorization of PL 94-437, the Indian Health Care Improvement Act. We (A.H.E.C.) hope that you will give just consideration to continued support in health care delivery for Alaskan Natives, which is helping to achieve long lasting results.

Many of the issues, our group addresses deals with health education or preventive health measures. We advocate the concept and practice of intelligent, informed decisions. It is our belief that health education leads to healthier lifestyle decisions. By making healthier choices, individuals can reduce the need for costly medical care.

Again, we thank you for your present support on the Senate Select Committee on Indian Affairs, and trust we can look forward to viewing a continuation of PL 94-437, the Indian Health Care Improvement Act.

Respectfully,

ALASKA HEALTH EDUCATION CONSORTIUM

Nancy Bill

Nancy Bill, President

NB/kc

cc: Denny Degross, A.N.H.B. ✓
File

Panel Testimony by the
AFN Human Resource Committee and the
Alaska Native Health Board
before the
U.S. Senate Indian Affairs Committee
Oversight Hearings on IHS and P.L. 94-437

On behalf of the Norton Sound Health Corporation and the people of the Bering Straits Region whom I represent, we commend the efforts taken by Congress and the Presidents to maintain and improve the health status of Alaska Natives required by the federal government's historical and unique relationship to Native Americans.

In the last decade we have seen improvements in our regional health facility. We have made the first steps in realizing our goals toward native manpower development, with the firm belief that this will begin to stabilize staffing of health care providers. We have instituted high standards incorporating the guidance of a consumer-directed board composed of representatives from all our villages and the community of Nome. Our contractual relationship with IHS has enabled us to create a unique Community Health Services system. This system, developed by us, includes primary Community Health Aides who are recruited in each village and who are trained and supervised regionally. Moreover, we have a community-based hospital which serves the entire population of about 8,000; of these approximately 80% are Alaska Natives.

Despite the gains we have directed, and despite those which have been afforded us by the efforts at the state and national level, we still have unmet health needs which must be addressed before we will reach parity with the health status of other American citizens. Our primary concern is that new members of Congress and others who make decisions which affect the delivery of health services to Alaskan Natives do not delude themselves into believing that these past efforts have cured the problems.

Most of our village residents haul ice for drinking water and use small pots, known as "honey buckets", for human waste disposal. The health and safety of these villages is endangered daily by inadequate sanitation. While some sanitation systems do exist, they were often poorly constructed for this environment and there has been little consideration for operation and maintenance. Without being too graphic in our description of water and waste disposal in rural Alaska, please imagine what life is like when every dish washed, every tooth brushed, and every diaper laundered must be accomplished with hand-carried water, and even the health clinics have "honey buckets" which are used by the ill patients. With nonexistent waste disposal, it is no wonder that we have a residual rate of transmitted diseases that have been all but erradicated among the rest of America, such as Hepatitis A, Salmonella, and Shigella.

Another significant health status indicator is infant mortality, which is still quite high among our people. Despite routine well baby check-ups and good prenatal and neonatal care by parents, meningitis deaths among infants still occur annually in our region. Those children who do recover are often impaired or disabled and require on-going special medical care during their life. While the infant mortality rate for white Alaskans has dropped from over 21 to less than 10 per 1,000 live births over the last decade, the rate for Alaskan Natives has only dropped from about 28 to about 21 per 1,000 live births.

Another disease which is not often considered a problem in the rest of America is tuberculosis. This is still being actively treated in rural Alaska. Not only are we treating active cases, but we regularly deal with the medical complications from the past epidemics.

In addition to these direct patient care needs, preventive care has been sadly neglected; increasingly so with the recent budget cuts and with no hope in the near future to address these needs. Examples of the greatest needs are accident prevention and medical problems associated with social concerns such as alcoholism, mental illness, dental caries, and eye and ear disorders. Furthermore, our people still suffer from poor access, limited communications and transportation systems, and severe climate, all of which make the provision of health care a difficult task, at best.

The high utilization of health services by the people demonstrate an increased confidence in the providers It also shows a positive outcome of the health promotion activities we were able to conduct in recent years before the drastic funding cuts. It is very important to us that the federal government not, at this time, attempt to convince itself that the health status of Alaskan Natives is at parity with the rest of the American population. Our people now trust that the providers are skilled; they now seek help early, and do not delay until a condition is chronic. To stop in mid stream the advances made so far would most certainly leave our people to be quickly swept back to their previous status before they realize the full health afforded their fellow citizens.

The 94th Congress took a step in the right direction when they enacted the "Indian Health Care Improvement Act." We endorse re-authorization of Public Law 94-437 and pursuant appropriations at a level which will allow full implementation of that act.

Alaska Native Health Board

STREET, SUITE 230 ANCHORAGE, ALASKA 99501 PHONE (907) 276-6089

Reference #A83-0601

June 3, 1983

Senate Select Committee on Indian Affairs
The Honorable Mark Andrews, Chairman

Dear Senator Andrews:

Enclosed please find:

> "Major Health Problems of Alaska Natives" which is a summary of the most current mortality and morbidity data for Alaska Natives.
>
> and
>
> Alaska Native Health Care in 1982, which is one of the best papers on health data, health problems and proposed directions to be developed about the Alaska Native population in many years.

Here is a quick, thumbnail sketch of what has happened with Alaska Native health in the past twenty-five years.

In the 1950s, Alaska Native health was among the worst of any ethnic group in the country. In 1954, the Parran Report brought national attention to these problems (high tuberculosis mortality; high infant and maternal mortality; and high otitis media morbidity). By 1970, T.B. had been largely wiped out; infant/maternal mortality was in significant retreat; and otitis media had been reduced to manageable levels.

Alaska Natives still have significant health problems, primarily in preventable disease/accident areas. Much of the health problems now faced by Alaska Natives are connected to the profound and often traumatic socio-economic changes occuring in the population.

Public Law 94-437 should be reauthorized, certainly. But it should be authorized at the levels intended by the original enabling legislation. The reasons why P.L. 94-437 was passed in the first place are still current: American Indians and Alaska

Natives experience health conditions that are the worst for any ethnic group in the entire nation. Reauthorization of Public Law 94-437 at the levels of funding we have seen will be helpful, but not enough to do the job as it needs to be done.

If you have further questions about Alaska Native health, please contact us.

Sincerely,

ALASKA NATIVE HEALTH BOARD, INC.

Kenneth B. Charlie

Kenneth B. Charlie
Chairman

DPD:KBC:blg

Enclosures

MAJOR HEALTH PROBLEMS

OF

ALASKA NATIVES

Prepared Especially For
The Alaska Native Health Board, Inc.
by
Cindy Demmert, MPH Intern
Alaska Native Health Service

June 3, 1983

Alaska Natives are disproportionately represented in the State's morbidity and mortality statistics. Although the health status of Natives has improved from its initial deplorable state at the time the Indian Health Service assumed responsibility for the health and medical care of Alaska Natives, health indicators verify that morbidity and mortality rates must be greatly reduced to reach the levels of other Alaskans and the general U.S. population.

Decreasing Native mortality rates and improving the general health status is a challenge due to outstanding demographic and geographic impediments. Traditionally, Alaska Natives live in rural villages which are literally and figuratively isolated from major urban areas. The village lifestyle is characterized by low socio-economic levels, few employment opportunities, poor sanitation and water supplies, and a traditional subsistence economy. Housing conditions of Alaska Natives, while improved through recent HUD projects, still indicate a much higher per capita occupancy of home dwellings than among non-Natives. Alaska Natives are a people in transition between two polarized cultures and the stress of this lifestyle is evidenced through high mortality and morbidity rates. The following Alaska Native mortality facts support this statement:

1. Alaska Natives comprise only 16% of the State's population but 28% of the State's mortality, whereas non-Natives make up 84% of the population and only 72% of the mortality.

2. Accidents are the leading cause of Native mortality, accounting for nearly twice the mortality of the number two cause of death which is heart disease and hypertension. Also, the Native mortality rate for accidents is three times the rate for non-Natives.

3. Heart disease and hypertension are the second leading cause of mortality, and Native mortality rates for heart disease and hypertension are one and one-half times that of non-Native mortality.

4. While Alaska Native infant mortality has been dramatically reduced from the high levels of the 50s and 60s through improved IHS prenatal and OB practices, Alaska Native infant mortality still remains several percentage points higher than that of non-Natives. (Native Range 18 to 32 p/1,000; non-Native Range 10 to 12 p/1,000.)

5. Overall mortality rates for Alaska Native men is twice that of Alaska Native women, which probably reflects the dangers of subsistence lifestyle.

Also, mortality rates for Natives aged 15 - 34 account for nearly one-third of all Native mortality in all age groups.

Morbidity data also reflects and supports trends in the mortality rates. Hospital data, discharge and inpatient days, show accidents, alcohol abuse, and heart disease to be the leading health problems for Alaska Natives.

Hospitalization by Average Length of Stay

Average length of stay within Alaska Area IHS hospitals usually differs according to type of diagnosis. For example, below is a listing of areawide diagnoses and their average lengths of stay:

Diagnosis	Average Length of Stay in Days	
	1980	1981
Accidents & Injuries	7.8	7.3
Alcohol Abuse	9.9	10.7
Delivery Without Complications	3.6	3.1
Heart Disease	8.6	7.6
All Diagnoses Combined	6.8	6.9

Hospitalization by Order of Discharge

-Accidents are still the leading cause of hospitalization in IHS facilities. Discharges of accident patients have increased 33.5% since FY 1980, and show a 79.4% increase for the two year period between FY 1979 and 1981.

-Six facilities reported accidents as the leading cause of hospitalization, and one facility reported deliveries as the leading cause of hospitalization.

-For all diagnoses combined, discharges have increased an average of 12.8% since FY 1980, and an average of 33.2% since 1979.

-Discharges for alcohol abuse show an increase of 50.9% over last year, however, discharges have increased only 12.7% in the two year period, FY 1979 to 1981.

-Discharges for malignant neoplasms have increased by 71.3% since FY 1979.

Hospitalization by Order of Inpatient Days

-Inpatient days required to treat accidents increased by 25.2% since last year, and have increased by 47.3% since FY 1979. Accidents maintain the lead in causes ranked by inpatient days.

-Five facilities reported accidents as the leading cause of inpatient days, one facility reported deliveries as the leading cause, and one facility reported Alcohol Abuse as the leading cause.

-For all diagnoses combined, inpatient days have increased an average of 13.5% since FY 1980, and an average of 23.6% since FY 1979.

-Inpatient days for perinatal conditions have more than doubled since FY 1979 - with a 151.6% increase in two years.

-Alcohol Abuse required 67.6% more inpatient days in FY 1981 than it did in FY 1979.

Treatment by Order of First Visits

-Accidents are still the leading cause of first visits, and upper respiratory problems follow with a close second. The number of first visits for accidents has increased by 16.1% since FY 1980, and 21.7% since FY 1979.

-Nine facilities reported accidents and injuries as the leading cause of first visits, five facilities reported upper respiratory problems as the leading cause, and one facility reported tests only as the leading cause.

-For all diagnoses combined, first visits have increased an average of only .9% since 1980, and have increased an average of 1.3% in the two year period FY 1979 - 1981.

-For the first time in at least ten years, strep throat is not one of the fifteen leading causes of first visits.

Treatment by Order of Total Visits

-Once again, accidents lead the causes of total visits, with an increase of 32.3% since last year, and an increase of 47.1% since FY 1979.

-Eight facilities reported accidents as the leading cause of total visits, three facilities reported upper respiratory problems as the leading cause, and one facility reported tests only as the leading cause.

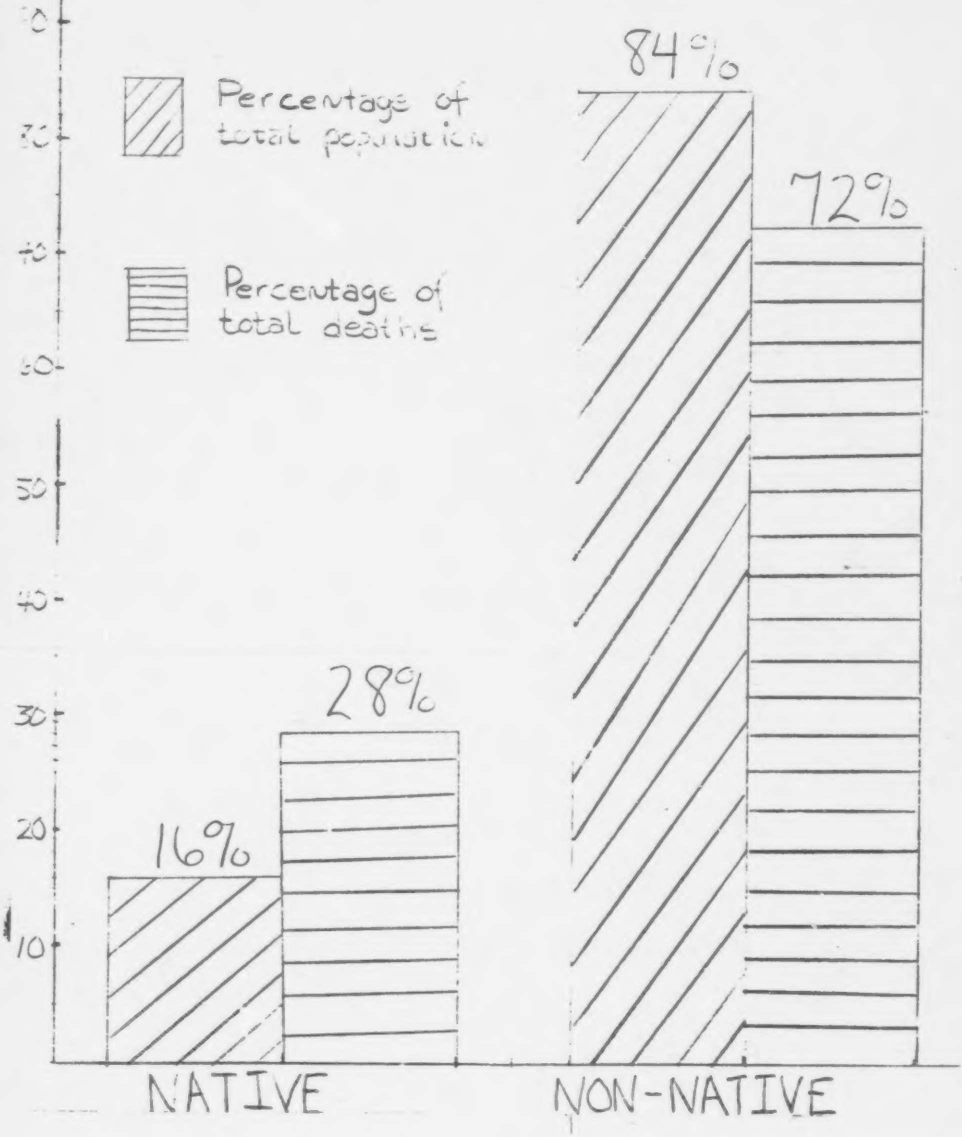
-For all diagnoses combined, total visits have increased an average of 17.2% since FY 1980, and an average of 32.5% since FY 1979.

-Total visits for both family planning and immunizations have more than doubled since FY 1979.

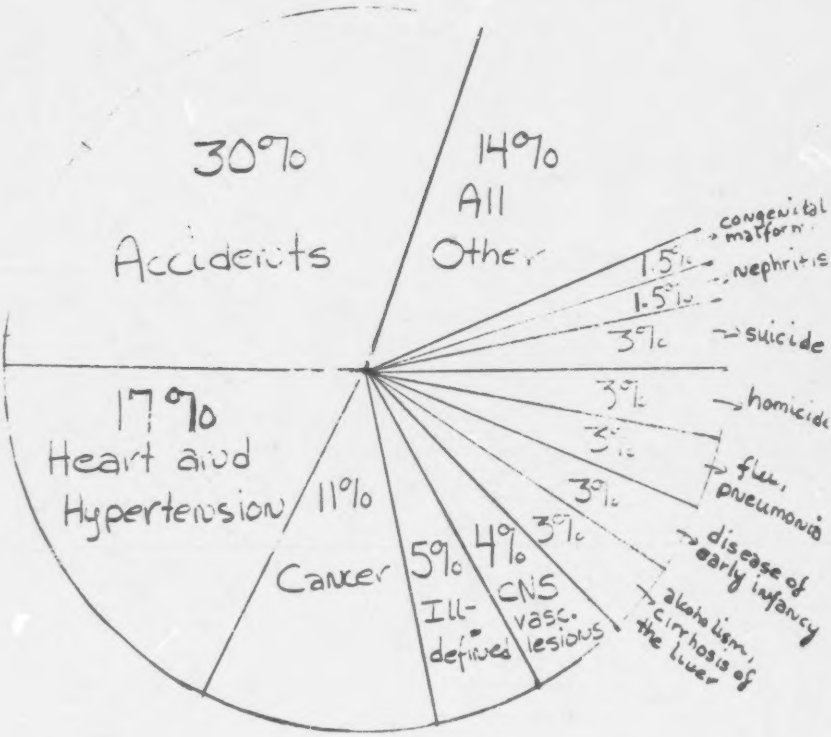
A 1980-81 examination of Anchorage paramedic runs also indicates a high Native ratio of emergency events (accidents, cardiovascular) with 34% of all ambulance runs from the airport to Anchorage medical facilities, compared to an actual 16% of the total population.

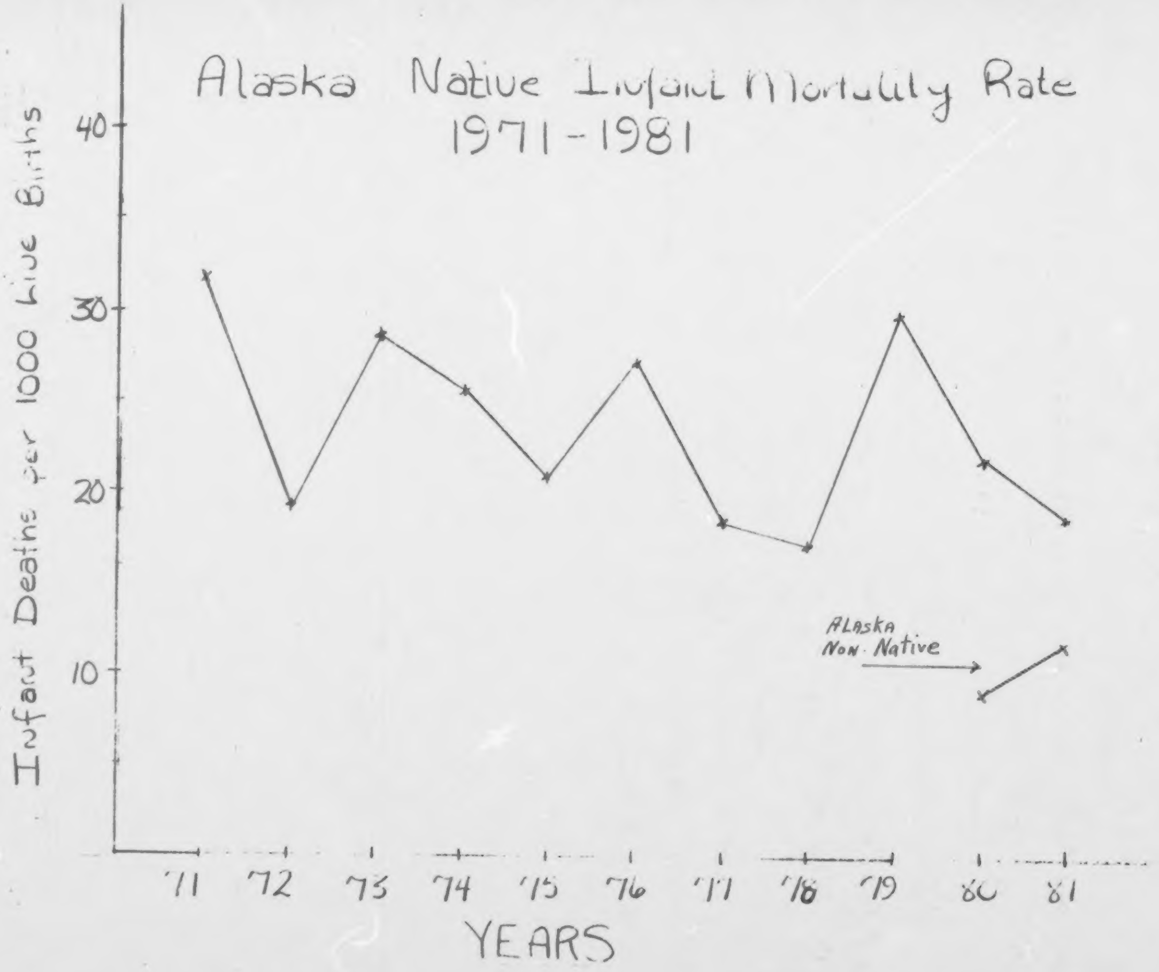
It is important to recognize that a large share of the health problems afflicting Alaska Natives are potentially preventable. This includes most accidents, cancers related to smoking and industrial contaminants, heart disease and hypertension, alcoholism, homicide, and suicide.

Comparison of Native and Non-Native Mortality, 1980-81



ALASKA NATIVE MORTALITY





Alaska Native Infant Mortality Rate
1971-1981

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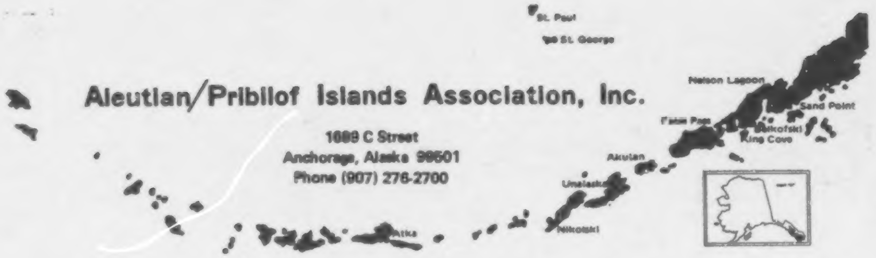
South Central Health Planning and Development, Inc.; "Alaskan Medevacs: Descriptive Study, Identification of Problems, and Possible Solutions;" pp 57; May, 1983



Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 276-2700

Testimony to United States Senate
Select Committee on Indian Affairs
Field Hearing--Anchorage, Alaska
June 3, 1983

Senator Murkowski, Acting Chairman
Fellow Committee Members

The Aleutian/Pribilof Islands Association is the regional non-profit arm of the Aleut Corporation, a regional corporation formed under the Alaska Native Land Claims Act of 1971. From its central office in Anchorage, the Association serves eleven communities which stretch westward for 1,130 miles. The total region encompasses 128,000 square miles. The eleven communities, three first class and two second class cities and six traditional villages are separated from each other by mountains, the North Pacific Ocean and the Bering Sea. The remoteness and isolation of these communities necessitates a central office in Anchorage close to the focal points of federal and state governmental agencies.

There are approximately 5,000-6,000 permanent residents in the region. In addition, there is an influx of transient fish processor workers into many of our communities throughout the year. We also expect that the growth of the off-shore oil industry will impact the populations of some of our communities.

Our region has been described by the United States Coast Guard as having the worst weather in the world. The Aleutian/Pribilof Islands region is known as the birthplace of the winds. It is not unusual for winds in excess of 60 MPH to blow for days at a time. Steady winds in the 15-25 MPH range are the norm for most communities. Rain, fog, rapidly changing cloud covers and visibility conditions make even the shortest air flights a 50/50 proposition and subject to delays, possibly for days at a time. These severe and unpredictable weather conditions greatly impact the physical and mental health of the individuals who reside in our region.

Distances to and between the communities in our region are great. Travel is both expensive and time consuming. Due to the specified transportation patterns, many inter-island flights are routed through Anchorage. This usually adds a day to a travel schedule. Two examples demonstrate the prohibitive transportation expenses. The distance from the island of Atka to Anchorage is 1,130 air miles. The round trip airfare is $938.00. The costs of a round trip ticket from St. Paul Island to Anchorage is $784.00.

There are few formalized health and social service resources available in the region. The Aleutian/Pribilof Islands Association maintains the primary health care delivery system in the region through use of Community Health Aides, Community Health Representatives, and Emergency Medical Service squads funded by the Indian Health Service. Two communities have hired additional medical support: the community of Sand Point has hired a Physician's Assistant and the City of Unalaska employs a Doctor of Osteopathy. These resources are available primarily to residents of the community in which they practice since no two communities are connected by a road system. Unlike many other regions in the State of Alaska, the Aleutian/Pribilof Islands region does not have a regional medical center where more sophisticated medical services are available. The residents of our region must travel to Anchorage (or the Lower 48) if they require such medical services as surgery, lab testing, diagnostic x-ray testing, etc. Most women must travel to Anchorage to have their children. As we have indicated earlier, travel is unpredictable, costly, and time consuming.

There are many issues which we could address today but time and space is limited. Our primary purpose is to inform the Committee about the very unique and extreme conditions that exist in our region. We want to focus the Committee's attention on our unique needs. Clearly, the geographic, atmospheric and economic conditions found in our regin dictate the implementation of specific approaches to the delivery of comprehensive health care. Even though we are a part of the State of Alaska, our needs are different from those of Nome, or Bethel or any other region. We believe that we must have an active voice in determining how service dollars will be spent. The conditions found in our region dictate a prevention and health education approach for the improvement of our people's health. Also, service dollars must be available for Aleut people to travel from their communities to sophisticated medical services in Anchorage if they so require these services.

The lifelines in our communities are the Community Health Aides, the Commuinity Health Representatives and the voluntary Emergency Medical Services squads. Presently, we do not have sufficient funding for full time employment of these individuals. Our seven CHA's are working 4.5 hours per day; our CHR's have been working 3 hours per day. We have no formalized health education program. In addition, we have had some difficulties in getting travel authorized for individuals requiring medical services at the Alaska Native Medical Center. We are concerned that transportation authorizations are being based upon the amount of travel dollars available rather than verified medical need.

Our health care delivery system is far from comprehensive. We believe the levels of service being provided are inadequate to facilitate and assure quality health care for our people. Decreased funding or the elimination of any of these services would remove the only patient health care delivery system in our region. It is unlikely that these services will ever be provided by other agencies, the State, or other health care providers.

I would urge the Committee to recognize the diversity of need among the regions of Alaska and the necessity for each tribe to set its own priorities and goals. Each service unit and tribal program faces differing circumstances and constraints in meeting the health care needs of its people. Providers and managers at the local level must be involved in making judgments about the optimum use of scarce resources. This is necessary to assure for our people, a high quality, healthy life. I appreciate the opportunity to present this written testimony.

Sincerely,

Kathleen M. Sutcliffe

Kathleen M. Sutcliffe, RN, MN
Health Director

SUMMARY ORAL PRESENTATION
SENATE OVERSIGHT HEARINGS ON
HEALTH CARE COSTS IN ALASKA
JUNE 3, 1983
ANCHORAGE, ALASKA

My name is William Dann of Nome, Alaska. I currently operate a health planning and management consulting firm which serves, among others, a number of Alaska's regional health corporations. For 13 of the past 15 years, I have worked in health administration and planning in Alaska, 10 years as director of the regional Native Health Corporation in Nome and 2 initial years as a hospital administrator for the Indian Health Service.

My testimony addresses two concerns with regard to Allocation of IHS health resources: inequitable treatment of the Alaska Area relative to other IHS areas and inequitable treatment within Alaska of the Native regional health corporations.

A summary of the points in my written testimony are as follows:

1. The current myth in Washington, D. C., that the State of Alaska or Alaska Native people can provide for their own health needs ignores a) the tremendous need of the State to close the gap with the lower '48 with regard to economic and social infrastructure thereby assuring a sound economic future, and b) the fact that the small profits that a few Native regional corporations have realized have not altered the stark economic realities of Native Alaskans.

2. A study by IHS's own Alaska Area Office (Alaska Cost Consideration Study, 1/24/83) makes the following points with regard to inequitable treatment of Alaska in the appropriation and RRM allocation processes:

A. Patient travel by air is required to access medical care and a health system that cannot be accessed is of little utility. Recent travel cutbacks, the concept of eliminating travel and the failure to allow for travel in the RRM methodology has and will adversely impact the health status of Alaska Natives.

B. The RRM methodology underestimates the cost of tribal positions in the case of the Community Health Practitioner (the indigenous primary care provider in each village) that is the largest category of tribal employees in Alaska by better than 53% (the Area Study indicates a 30% deficiency).

C. Failure to appropriate sufficient indirect costs or to allow for such a category in the RRM methodology has stunted the opportunity of tribal contractors to assume control of IHS programs and supplement them with non-federal revenue. Currently, the benefits of a takeover must be weighed against the loss in direct service that would result from having to finance administrative costs. Further, current plans to deduct all non-federal revenue from dollars made available to contractors serves to take away much of the incentive to contract and/or to hear the added administrative cost of going after these revenue sources. It should be added that the same penalty for aggressive third party revenue collection is also being contemplated within the IHS system. Given that Service Units are already overtaxed, it would be foolish for administrators to allocate energy to these efforts as revenue does not return to benefit the facility.

3. In general, the RRM methodology is deficient in the following ways:

A. Criteria are unrealistic such that IHS will not even request funding to bring services above the 50% deficiency level.

B. Attempts to shoehorn Alaska's unique health delivery mode and cost realities into a national allocation system are very problematic.

C. Criteria lack cost-effective standards but rather project on past practice thereby cementing inequities.

D. Only selective cost are compared.

4. Budgeting procedures and the RRM criteria discriminate against tribally-operated programs in the following ways:

A. There is no allowance for the fact that as community hospitals, tribally-operated hospitals must be self-sufficient in administrative areas such as finance personnel, purchasing, and patient billing.

B. Allocations to tribal contractors do not factor the costs of the federal retirement program, medical education of commissioned officers, subsidized housing and other hidden federal costs that must be born by tribal contractors to be competitive.

C. The RRM projects past costs per unit of service in determining contract health care needs. Although appropriate for hospitals in which availability of IHS contract health care dollars do not constrain costs, tribal contractors, for whom IHS beneficiaries are a majority, the patient population are forced to hold overall costs within IHS dollars available or provide free care to beneficiaries. Projecting past constraints does not reflect true need.

In conclusion, the net effect of these inequities is that current allocations to Alaska do not realistically reflect comparative needs. Further, allocations to tribally operated programs constitute a violation of Sec. 106(h) of the Indian Self-Determination Act intended to assure equitable treatment of tribal contractors.

Thank you for the opportunity to offer testimony on allocation of IHS resources to Alaska. Further, the interest of the Committee as exemplified by their holding the hearing in Alaska is greatly appreciated.

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TESTIMONY BEFORE
SENATE OVERSIGHT HEARINGS ON
HEALTH CARE COSTS IN ALASKA
JUNE 3, 1983
ANCHORAGE, ALASKA

My name is William Dann of Nome, Alaska. I currently operate a health planning and management consulting firm which serves, among others, a number of Alaska's regional health corporations. For 13 of the past 15 years, I have worked in health administration and planning in Alaska, 10 years as director of the regional Native Health Corporation in Nome and 2 initial years as a hospital administrator for the Indian Health Service.

My testimony addresses two concerns with regard to allocation of IHS health resources: inequitable treatment of the Alaska Area relative to other IHS areas and inequitable treatment within Alaska of the Native regional health corporations.

ALLOCATIONS TO ALASKA

Introduction

By way of introduction, it has become clear over a series of discussions with Congressmen and Office of Management and Budget Planners that Alaska is falling prey to an overt proclivity to deny it federal social service funds based on a belief that the newly acquired wealth of the State through oil taxation revenues (which it is pointed out come from the pockets of lower '48 petroleum patrons) should be picking up those programs. Advocates of Alaskan Native health needs are advised to stay away from Capital Hill for fear that Congress may remember that they exist and that somebody thought a good place to find savings in federal programs was to transfer them to the State of Alaska or regional Native corporations. In the words of one OMB Analyst I spoke with, "it's not that we're abandoning the federal trust responsibility, it's just that you can't expect to make great profits off Federal land and also have the federal government pay all the costs of education, health, and social services."

There are some myths regarding Alaska's wealth that need to be understood:

1. Alaska's economic and social infrastructure still lags far behind the lower '48. Roads, public facilities of all types, sanitation facilities, safe water sources, airports, and renewal resources or industry should be the focus of State investments for Alaska to stand on its own. Several years of such investment would be required to approach parity with other States.

2. The profits that a few of the regional for-profit corporations have generated have not impacted the financial status of individual Native families. Family income, unemployment and other economic indicators exemplify the continuing extensive needs of Alaskan Natives.

3. The prices in Alaska remain staggering--examples from Nome: gasoline, $1.84 per gallon; milk, $2.99 per half-gallon; electricity, $.22 per kilowatt hour.

4. The costs and methods of provision of health services in Alaska (to be touched on later) are so high relative to the lower '48 that comparisons with other IHS Areas are extremely problematic for policy making purposes.

Alaska Cost Considerations Study

A January 24, 1983, Study by the IHS (see attachments) details a number of area findings of inequities in IHS Headquarters allocations to Alaska including the Resource Requirements Methodology (RRM).

Summarizing and expanding on this Alaska Area Study, I would make the following points:

1. Personnel - The 16% reduction in Alaska Area employment over the last two years has severely impacted direct service. Turnover in administrative positions, especially at the Area office, tends to be lower than nurse, housekeeping, and other positions vital to patient care. The Association of Regional Health Directors have several times over recent years requested that RIF (reduction in force) authority be granted to IHS to enable needed direct service positions to remain filled.

2. Patient Travel - In most of rural Alaska, access to skills beyond that of an indigenous primary care provider (e.g. - physicians assistant) requires air travel on a year-round basis. Typical fares would be $120 round trip in the Norton Sound region. Services of a specialist in Anchorage would then require an additional $300 round trip. In other words, it's like traveling from Los Angeles to New York to see the first available pediatrician, surgeon, etc. The well-designed tiered health care delivery system of IHS requires access by patients to be effective. Itinerant specialist travelling to the "bush" regional hospitals to follow-up on patients require that their patients be able to travel in to see them to be at all effective. Yet, RRM methodology fails to account for these important costs and policy makers would appear to intend to exclude travel from the IHS program.

3. Contract Health Care - Both the Alaska Study and the July 2, 1982, GAO Report "Indian Health Service Not Yet Distributing Funds Equitably Among Tribes" are critical of the IHS "longstanding practice of funding programs and tribes based on the previous year's funding level (program continuity)" (GAO Report, p. 15). The practice perpetuates past inequities which the Alaska Area alleges to be the case with regard to Alaska's share of contract health care funds (Cost Study, p. 10).

4. Tribal Positions - The Alaska Cost Comparison Study asserts that tribal positions are being underfunded by IHS because the actual cost exceeds the RRM budgeted figure by almost 30%. However, the Alaska Area Study uses a conversion to the GS schedule in developing this figure. Actual costs for a trained Community Health Aide at the Norton Sound Health Corporation which were developed by Hay Associates, the largest wage and salary consulting firm in the world, are an additional 23% above the 65 conversion or 53% above the RRM methodology. Whereas these are the largest single category of health employees in Alaska, the impact of this methodological deficiency is significant.

5. Indirect Costs - The Alaska Area Study argues for inclusion of tribal indirect (i.e. administrative) costs in the RRM methodology because of the significant percentage of the overall program that is contracted to tribal groups. Non-inclusion discriminates against Alaska it is argued. Lack of indirect cost funds have served to discourage tribal contractors from assuming more of the IHS program as administrative costs would reduce dollars available for programs. Discouraging contracting, in turn, discourages access to private health insurance and other revenues to supplement IHS resources.

6. Village-Built Clinics - With 40,000 beneficiaries spread over 198 villages, IHS is faced with extraordinary per capita costs to provide primary care to residents in each community. Yet, such a system is necessary for access to medicines, emergency care, preventive care, evaluation/referral services, and trained extension by radio of the physician. The Community Health Practitioner trained in each village must have a facility within which to provide treatment, store medicines, aggregate records, and carry on confidential patient and physician communications. To lease such facilities from each village is extremely costly. Not allowing for this unique Alaska cost in the RRM criteria has penalized Alaska.

7. Overall Methodology - The last point made in the Alaska Cost Consideration Study as well as the GAO Report is that the RRM methodology ultimately fails because it does not include all sources of funds.

RESOURCE REQUIREMENTS METHODOLOGY

There are several concerns regarding the RRM allocation criteria that are not adequately addressed in either the Alaska Area or GAO reports.

1. The methodology lacks cost-effective or efficiency standards.

Hospital resources are allocated based on patient days without regard to whether the average length of stay is appropriate. Within the methodology, a hospital is a hospital is a hospital. Reality is that "bush" hospitals require certain core staff to remain open and poised to meet needs of their regions. Allocating resources to these hospitals based on patient days may well underestimate needs. Conversely, referral hospitals such as the Alaska Native Medical Center can adjust staffing to reflect workload. In these instances, a standard for average length of stay that incorporates difficulties such as the need to retain patients somewhat longer due to inability of the specialist to teach them on an outpatient basis once they return home. Lack of such a standard can serve to reward inefficiency.

2. Criteria are unrealistic.

As a matter of policy, IHS has chosen to no longer request Equity Funds once all tribes have reached the 50% deficiency level. On the face of it, such a policy bespells problems with criteria. A well-planned health system could not survive with only 50% of needed resources. Further, attempting to apply those same criteria to the health system in Alaska that is unique in design, logistics and cost factors is very problematic.

For example, in an attempt to account for a small population spread out over communities of 100 - 500 people, the initial RAC application for the Norton Sound region showed the need for some 50 additional Emergency Medical Technicians as it assumed road access to the hospital. A subsequent application called for over three times the primary health care providers or Community Health Practitioners that now exist.

ALLOCATIONS TO TRIBAL CONTRACTORS

The following deficiencies in the RRM criteria are particularly problematic to regional health corporations that have contracted to provide services to IHS:

1. Indirect Costs.

A contracted hospital must become administratively self-sufficient. Purchasing, personnel, finance, patient billing, clinical consultation and other services must be provided for by the tribe under contract. RRM does not allow for such resources at the Service Unit level.

2. Tribal Personnel.

Appropriations and RRM assume that tribal personnel are affordable at GS schedule costs. Reality is that federal retirement, subsidized housing, subsidy of medical education to Commissioned Officers, are among the "hidden" costs in IHS operations that are not provided to tribal contractors. In essence, this practice violates Sec. 106(h) of the Indian Self-Determination Act intended to assure equity for tribal contractors.

3. Contract Care.

The RRM methodology projects previous per visit or per day costs as a basis for projecting "needs" for contract health care funds. This works well for community hospitals for whom IHS beneficiaries are a small percentage of total business. However, for the contracted hospital in rural Alaska, beneficiaries (i.e. Native patients with no alternate form of payment) constitute a large percentage of total business. Therefore, the dollars available from IHS determine the overall operating budget and, hence, the cost per unit of service. Projecting a cost per unit of service under such constraints does not project true needs. For such facilities, a direct allocation method such as that used for IHS Service Units, that allows for costs of autonomous administration should be used.

4. Outpatient Care.

The RRM criteria utilizes a measure of outpatient visits that includes visits to the pharmacy only. However, general health industry practice and the practice of many tribal contractors would exclude such visits. Definitions must be sufficiently clear and standardized reporting established such that tribally operated facilities are afforded "apples and apples" comparisons.

5. Consult with Tribes.

Procedures should be established to afford tribal input into the RRM allocation method or subsequent efforts to provide equity between tribes. Means to this end might include the following:

A. Consultation on criteria development and modification.

B. Published standard definitions and reporting requirements.

C. Provide for tribal review of submissions of RRM applications to tribally-operated programs.

D. Orientation of regional health directors to the RRM criteria.

Thank you for the opportunity to offer testimony on allocation of IHS resources to Alaska. Further, the interest of the Committee as exemplified by their holding the hearing in Alaska is greatly appreciated.

INUPIAT ILITQUSIAT GOALS

TEACH HUMAN (INUPIAQ) VALUES

DEVELOP INDIVIDUAL IDENTITY AND SELF-ESTEEM

DEVELOP INCENTIVE AND MOTIVATIONS

DEVELOP USE OF INUPIAQ LANGUAGE

PRESERVE INUPIAQ CULTURAL HERITAGE

TEACH TRADITIONAL JOB SKILLS

BASIC PRINCIPLES

1. Every Iñupiaq is responsible to all other Iñupiat for the survival of our cultural spirit, and the values and traditions through which it survives.

2. Through our extended family, we retain, teach and live our Iñupiaq way.

3. Elders are responsible for cultural survival and transmission of traditional values and skills.

4. Iñupiaq is the medium through which cultural identity will be transmitted.

5. Iñupiaq is the language that traditional values and skills will be taught in.

6. Our understanding of our universe and our place in it is a belief in God and a respect for all His creation.

7. Our land is the physical symbol of our Iñupiaq spirit.

EVERY INUPIAQ IS RESPONSIBLE TO ALL OTHER INUPIAT FOR THE SURVIVAL OF OUR CULTURAL SPIRIT, AND THE VALUES AND TRADITIONS THROUGH WHICH IT SURVIVES.

THROUGH OUR EXTENDED FAMILY, WE RETAIN, TEACH, AND LIVE OUR INUPIAQ WAY.

Each individual must make a personal commitment to the survival of the Inupiaq spirit. Each new day is a new chance to contribute.

Our extended families include our whole village, since we are all related physically or spiritually.

In the village:

Spirit Committee Programs, village schools, should help young people learn their kinship ties within the village and with other villages.

Parents should take advantage of extended families in raising children, especially in values teaching.

In the region:

School District, KOTZ, Television and others should create books and programs to teach us Inupiaq history, migrations, leaders of the past, and our common cultural heritage.

With guidance and support from Elders, we must teach our children such Inupiaq values as self-discipline, endurance, patience, sharing conflict avoidance, honesty, and respect for others for the welfare of our village life.

By preserving and teaching our traditions, we will have a way to teach values, show young people how to get along on the land, provide alternative job skills, and give every Inupiaq a chance to become expert in at least one area of our heritage.

In the village:

Spirit Programs should allow Elders to teach traditional skills to younger people. Each village will make its own choice of what and how to accomplish this.

School programs teaching traditional skills should use traditional teaching methods, in large enough blocks of time to ensure effective learning.

School calendars and schedules should allow young people to accompany their families to camp so they can learn in a traditional way.

Elders should be in charge of day care and early childhood education programs in every village.

In the region:

Regional organizations should offer space and other resources to support village spirit programs.

School district should have a policy for the teaching of traditional skills in the traditional way.

We must learn to see school, cash income, and jobs as means to preserve Iñupiaq spirit, not as goals in themselves.

ELDERS ARE RESPONSIBLE FOR CULTURAL SURVIVAL AND TRANSMISSION OF TRADITIONAL VALUES AND SKILLS.

We must restore our Elder's authority to set standards of behavior in our families and our villages.

In the village:

Elders' Councils must take a stand against destructive and self-destructive behavior.

If possible, villages must restore real authority to our Elders to judge and control bad actions.

Villages, police and courts must work to develop atonement for bad actions which allow for community service and putting Inupiaq values into practice.

Families must teach their children to give great respect to the needs of the Elders, and young people should start now to offer their help to Elders in need.

Children should learn from their early years on that the responsibility for the survival of the Inupiaq spirit is of the greatest importance.

In the region:

Radio, television, and newspapers should reinforce Inupiaq values in their programs and announcements.

Regional organizations should continue to push for local control, to give our Elders full use of their traditional authority.

In the region (continued):

Regional organizations should continue to offer services to people whose social problems are so serious that they can't be helped in extended families and villages. The goal should be to return these people to an extended family setting.

Elders must be respected for their knowledge of language and skills, and should be given a meaningful chance to educate children at home and at school.

In the village:

Programs for the education of little kids should be staffed and run by our Iñupiaq-speaking Elders.

In the region:

Pay and career ladders for jobs that require experts in Inupiaq language and culture should show the value these abilities have to our culture. A minimum consulting fee for elders or others with Inupiaq expertise based on $100 should be paid.

We ask Elders to pick occasions for ceremonies and celebrations to mark the progress of young people to maturity as contributing Iñupiaq adults.

In the village:

Ceremonies might be held on such occasions as:
birth, naming, first game taken, first large game taken, first traditional tools and clothes made, graduations, weddings, seasonal food-gathering done by the entire village, special honors, and funerals.

Ceremonies and village gatherings should be a place for traditional ways of expressing ourselves, such as the arts, song and dance, stories, spiritual observations, and sharing of achievement.

Ceremonies should give the whole village a chance to participate, from babies to Elders.

Some ceremonies should be held at times when those who have moved away from the village are home to visit (holidays).

In the region:

Region-wide gatherings, such as church meetings, NANA Annual Meeting, Trade Fair, Elders Conferences, should be continued and should focus on traditional values and activities. Recognition should be given for excellence in traditional pursuits such as hunting and domestic skills.

Regional organizations should provide support for village and region-wide ceremonies and celebrations.

Regional media (radio, tv, newspapers) should publicize and promote these celebrations. At Annual Meetings, new shareholders who reach age 12 will re recognized.

With authority of the Elders Councils and help from formally-educated adults, we must find ways to use western institutions, such as schools and governments, to promote Inupiaq values and lifestyle.

In the village:

Schools are well-suited to teach job-holding skills and citizenship, which are necessary for Inupiaq survival into the future.

Through influence, Elders can help us elect or appoint people to village office and regional boards who will be active in guiding these western institutions in the Inupiaq way.

Elders can request Board representatives to report to the Council about the business conducted at meetings of regional Boards.

Village governments take an active part in the Regional Strategy Planning effort. This will help our representatives and technical people to work for our people's best interests.

Parents in each village can become involved in their kids' schooling. They can attend school committee meetings, parent conferences, and demand teachers who expect the kids to achieve. They can support discipline at school by teaching self-discipline in the home.

Citizens must learn not to expect newcomers to understand how to promote Inupiaq values. It is easier for Inupiaqs to learn how to work with western institutions, and it is our responsibility to make these organizations serve our needs.

In the village (continued):

Non-natives who come to live among us and help us should be encouraged to participate fully in our extended families and our community activities.

Parents, families and villages should help young people who try for education and jobs that will help their people, and must be urged to stick with what they set out to do.

In villages, people and groups can develop economic opportunities that are based on traditional knowledge: arts and crafts, subsistence farms, guiding and survival instruction, etc.

In the region:

Regional organizations should join together to come up with an orientation program for newcomers that will help them understand Iñupiaq values and how we want to use them to deal with our problems. This should not be undertaken by the School District.

The School District should develop guidelines and help for teachers who need to learn teaching methods that build on Iñupiaq strengths, instead of western values like competition and individual achievement.

School District, KOTZ, ITV, newspapers, and others should develop and distribute books, programs, and courses that will teach us our history, geography, science and natural history, biographies of past leaders, literature, the arts, and all other aspects of our culture. We need to know these as much as we need to understand western history and culture.

NANA should pursue its approach to human resource development as an economic development policy, including help and support for village-based alternative income programs and efforts.

INUPIAQ IS THE MEDIUM THROUGH WHICH CULTURAL IDENTITY WILL BE TRANSMITTED.

INUPIAQ IS THE LANGUGAE THAT TRADITIONAL VALUES AND SKILLS WILL BE TAUGHT IN.

In order to ensure the survival of our language, we must focus first on teaching those who are still young enough to learn easily.

In the village:

Speakers of the language must be convinced to use the language constantly with youngsters.

Day care centers should be staffed by Inupiaq-speakers only.

Early childhood education programs should be staffed by speakers and all teaching should be in Inupiaq only.

Children in grades kindergarten through third should be taught oral Inupiaq to the point of fluency. Older children should be taught to read and write the language.

In each level, a head teacher should be named who will make sure that only Inupiaq is used where that is the policy.

Inupiaq education for high school students should include history and culture of our people and other Inuit people in the world.

In villages where the language is still strong, Inupiaq should be the primary language for public meetings.

In the region:

KOTZ, ITV, and others should greatly increase the amount of programs in Inupiaq. All important information should be announced in both languages.

School district policy giving equal emphasis to both languages should be continued and supported. Efforts to create teaching materials for Inupiaq courses should continue and be helped by all who have something to offer.

Teaching conditions and training of Inupiaq instructors should improve. They should get the support they need. Payment should reflect the value of their special skills.

Programs must be developed to help those out of school to learn, relearn, and improve their Inupiaq language skills.

In the village:

Elders must insist that learners be treated with respect and not be blamed or ridiculed for not learning the language as children.

Village spirit programs should designate teachers and other resources to teach Inupiaq to non-speakers, and literacy to speakers.

In the region:

College-level courses in Inupiaq language, heritage, and teacher-training should be developed and offered.

Teaching materials for adult beginners should be developed and made available. This could include radio and television programs.

New employees should be required to take a conversational Inupiaq course.

New ways to revive language ability or to teach a new language to adults should be investigated and used, especially at the Community College.

Young adults should be informed by regional institutions about career opportunities based on knowledge of language and the culture.

High school students should be told now of programs to get needed skills in language teaching and materials development, where there is a real manpower shortage.

The Inupiaq Language Commission should have the authority to set language policy for the region, since its people have the most experience and commitment to the survival of the language.

In the village:

Members of the Language Commission should make their membership known to the Elders, and seek advice and help in creating programs in the village.

In the region:

The School District should finance regular meetings of the Language Commission and offer it staff support.

Other regional organizations, such as the Museum and Maniilaq, should help the Commission to get funding.

In the region (continued):

At regular Language Commission meetings, planning for and evaluation of programs should be a part of the agenda.

Local media (KOTZ, ITV, newsletters) should report on activities of the Language Commission.

OUR UNDERSTANDING OF OUR UNIVERSE AND OUR PLACE IN IT IS A BELIEF IN GOD AND A RESPECT FOR ALL HIS CREATION.

OUR LAND IS THE PHYSICAL SYMBOL OF OUR INUPIAQ SPIRIT.

By developing strong and self-disciplined adults, we will ensure ourselves of future leaders who can use the western system to promote the survival of the Inupiaq spirit.

By promoting the survival of the Inupiaq spirit through our village and regional programs, we will also promote the survival of a full and meaningful life for our people on our land.

By retaining and teaching our traditional skills, we can develop economic opportunities for our people that are compatible with a lifestyle close to the land..

By staying close to the land, we will stay close to God.

1521 G Street
Anchorage, Alaska 99501

June 2, 1983

Senator Frank Murkowski
Room C-521
701 C Street
Anchorage, Alaska 99501

RE: Community Health Aides

Honorable Senator,

I would appreciate if the following remarks were read into the record during a hearing to be held June 3, 1983 regarding the Indian Health Care Improvement Act, PL 94-437.

The Community Health Aide Program (CHAP) has enjoyed excellent support from congress since funds were first provided for training and salaries for the Community Health Aides in 1968.

Today the CHAs are, except for individuals involved in education, the largest group of native Alaskans who are employed in their own communities as a result of the training and support they receive. The services they render are essential to the health and welfare of citizens living in rural communities throughout the state.

It is the impression of many of us in the health field that the cost/benefit of this program is outstanding in a area where costs are an acknowledged problem.

While I realized that competition for health service funds is strong, and that there is a need to control the federal budget, may I ask that you and your committee give the Community Health Aide Program a high priority for continued support. While the state is moving to give more support to the program, federal funds will continue to be needed in the foreseeable future.

On the basis of many years of close association with the Community Health Aides, I can assure you that they will continue to give of themselves and their time in service to their communities. Your support will be deeply appreciated.

Respectfully,

M Walter Johnson, MD

M. Walter Johnson, M.D.

cc: Jim Sozoff, Chief
Community Health Aide Program
Alaska Native Health Service

Trudy Wolfe, President
Statewide Health Aide Association

June 3, 1983

TESTIMONY OF STATE SENATOR JOE P. JOSEPHSON TO THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS ON THE INDIAN HEALTH CARE IMPROVEMENT ACT

Language endorsed by Congress is 1976 by the passage of PL 94-437 was a major commitment by the government to the "historical and unique legal relationship with, and resulting responsibility to, the American Indian People." The law cited many areas where lack of services or insufficiency of existing services threatens the health status of Native Americans, targeting these areas for upgrading.

Section 2(b) of the law states that, "A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of these services." As of this date, that national goal has yet to be reached.

Since 1849, the government has been providing direct medical services to Indians and, particularly since the 1960's has radically upgraded the health status of Alaskan Natives. It is no secret that these rural Alaskans have suffered the worst conditions following acculturation: tuberculosis, syphilis, otitis media, small pox and other epidemics vastly reduced their numbers.

The development of the Indian Health Service, with related programs, have finally brought Alaskan natives closer to national standards in mortality and morbidity_. Budget cuts in recent years, however, are undermining the very basis of the health delivery systems:

1. Village Community Health Aides (CHA) are often the only providers of health care in rural areas. The CHA, who is selected from the population served, has a high status in the community with deep and respected ties to the people. Any cuts in services and training programs diminish the only primary source of care available in rural Alaska.

2. Transportation is very expensive in Alaska when most patients must travel by air for hundreds of miles to a hospital. Transportation costs also often include an escort and room and board costs while awaiting services or weather clearance to fly. Cuts in transportation funding over the last few years have strained state resources.

3. Coupling transportation reductions with cuts in contract care has been of serious consequences. Transportation funding is being denied at the same time that traveling health specialists are no longer able to provide health services within the community.

4. Telephone contracts are of major importance in rural Alaska, not only for the CHA's direct contact with a physician, but because many villages have only one phone link and the cost is prohibitive for the community to bear.

5. Community Health Representatives funding has rapidly diminished in the last two years in phasing out the program. These resource persons have provided a variety of health care development and educational functions tailored to community needs. Most preventive health programs were developed through CHA's in addition to coordination of services with the Community Health Aid and the Public Health Nurse.

Although Alaskan Natives have realized large improvements in health status, there are areas needing attention: mental health care, substance abuse, preventive care and village safe water and sanitation projects. The Native population is at high risk for accidents, alcoholism, heart disease, suicide and homicide. Alcohol abuse has been the single most important factor in accidental death and injury, with a death rate for alcohol-related problems over 10 times that of non-natives.

Without the development of a clearly defined federal policy on health care issues for Natives, a variety of services through non-profit corporations and the state have resulted in piecemeal efforts to fill gaps. Budget cuts in recent years have compounded these problems so that planning and coordination of services is virtually impossible.

All studies of native health services in Alaska over the last few decades have made the same observations which have yet to be addressed.

1. Lack of coordination between state and federal governments in the provision of services.

2. Inadequacy of a national policy and yearly appropriations to IHS.

3. Lack of adequate mechanisms for the delivery of services.

4. Lack of oversight and accountability of service delivery systems.

5. Lack of responsiveness of state and local agencies toward Indians.

6. Lack of comprehensive planning.

The absence of defined services provided by IHS and the level of expenditures have annually created problems in organization and planning. The nature and intent of the Natives right to good health have been contingent on the appropriations process. Throughout most of Indian history, available health services have been tied to the amount of money available and IHS unit officials' determination of services provided through available resources. Although the government is committed to providing the "highest level" of health care to Natives, there is no obligation to services or a definite level of funding.

The Native ends up with a general right to health services that vary from day to day or year to year with no written guidelines available to patient or provider. Without any legal standard for Congress to measure the provisions of services, the funding level remains constantly arbitrary; perpetuating generations old problems on the present Native population and IHS administrators.

Clearly we all realize that the amount of money available for any service is finite, and that remains true for state as well as federal funds. This is all the more reason why a coordinated effort by both governments has because a necessity in planning and avoiding duplication of expenditures.

The creation of a joint federal/state commission on Native health care could provide for optimum use of available funds, reduce state concerns of treading on federal "responsibilities," and substantially assist local Native entities in assuming their role of provider of services.

It is already clear that a partnership exists between the two governments in the provision of health care to Natives, what is needed then is a definition of the role of each. The existence of this dual system of health care has always created confusion over public health responsibilities in Alaska. Changing levels of appropriations and management decisions by IHS forces the state to respond after the fact to fill gaps in services, after spending the better part of each year trying to anticipate changes which might occur.

The state of Alaska has made, and continues to make, an enormous commitment to health care in Alaska. What I am asking is that both governmental bodies cooperate in the planning and provision of services so that we are not operating with unknown factors and that we all spend our health care dollars in the most cost-effective and beneficial manner.

Another issue that I would like to address is the change in policy currently before you.

I understand that OMB has considered several proposals to supplement Indian Health Service funding with charges to individuals and third party payers. Although it is cost effective to make IHS the last payer, I seriously doubt that a large number of Natives are in the position of having health insurance coverage.

Instituting a system of charges, even with a financial means test, is considered by many as a departure from the existing policy of the government and the historical obligation to Native peoples.

To make the Indian Health Service a "welfare" program will certainly cause bitter feelings and intense opposition. Considerations of this proposal must delve into the policy ramifications of any move that would abrogate the existing trust relationship.

In closing, I must say that the Indian Health Care Improvement Act is in desperate need of reauthorization. We have only begun to deal with the unmet health care needs of the Native population of this country, so this is not the time to withdraw from our responsibilities.

Finally, your serious consideration of the development of a joint state and federal commission established with the renewal of the Act would assist all lawmakers.

Maniilaq Association

Senior Citizen Center
P.O. Box 250
Kotzebue, Alaska 99752
(907) 442 - 3590

P.O. Box 256
Kotzebue, Alaska 99752
(907) 442 - 3311
Alcoholism Program (907) 442 - 3914

Public Health Nursing
P.O. Box 179
Kotzebue, Alaska 99752
(907) 442 - 3313

December 3, 1982

Radio Message (community announcement ran from noon till 6 p.m.)
KOTZ
Kotzebue, Alaska 99752

12/3/82

To: All Elders

A short meeting will follow dinner tonight. Also a movie called "Eskimo", will be shown at 6 p.m. tonight at the Senior Center. All Inupiaq Elders are encouraged to attend.

Our First Positive Elders Meeting

5:45 p.m. Following dinner, I met individually with local Elders as they left their meals at the Senior Center of Kotzebue. I distributed (1) Ilitqusait '82 Community Organization Conference scheduled for December 13-17, 1982 at Sivuniuliq Camp (2) Alcoholism Program at Maniilaq Association. (Copies enclosed) There were 25 Elders present. We began our short meeting by reviewing the two sheets of hand outs.

Action taken: Upon my return from the Sivuninliq Camp we will hold an informal follow-up meeting about the December Conference.

It was suggested by the Elders group that they meet January 12th 1983 (1 p.m.) at the (Ferguson Building) Conference Room. (This will be a part of their Inupiat Day activity.) Their concerns are ways to get them to the meeting. I'll need help coordinating transportation.

Taiku. Inupiat Ilitqusiat Office

Bertha Lowe

BL/cp

ILITQUSAIT '82
COMMUNITY ORGANIZATION CONFERENCE
IS SCHEDULED FOR DEEMBER 13-17, 1982
AT SIVUNIULIQ CAMP

YOUR LOCAL REPRESENTATIVE WILL BE AMY JONES. YOUR COMMENTS CAN BE RELAYED TO US ON YOUR VIEWS.

PLEASE CALL BERTHA LOWE AT 442-3313 SHE IS WITH THE MANIILAQ INUPIAT ILITQUSAIT OFFICE AT THE FERGUSON BUILDING. SHE WILL HELP YOU.

YOUR PROGRAM IN KOTZEBUE NEEDS YOU "THE ELDER'S" BEFORE WE CAN BEGIN TO SUPPORT YOU. IN RELATION TO OUR ALCOHOLISM PROBLEMS I WOULD LIKE TO KNOW HOW YOU CAN HELP US.

THEY ARE IN THE ALCOHOLISM CENTER

1. ELDERS TO SHARE ABOUT INUPIAT VALUES WITH CLIENTS ARE NEEDED AS SPEAKER'S ON FRIDAY, DECEMBER 17TH AT 10 A.M. HELD AT THE FERGUSON BUILDING.

   YOU ARE OUR
2. ELDERS, WHOSE SHARING COULD ESTABLISH PRIDE TO CLIENTS WITH PROBLEMS OF IDENTITY.

3. WE NEED YOUR HELP TO FIND OUT: WHAT YOU THINK WILL BEST HELP OUR COMMUNITY AND REGION ON TOPIC OF ALCOHOLISM.

WE WILL PLAN A FOLLOW-UP MEETING UPON OUR RETURN FROM THE DECEMBER CONFERENCE. PLEASE HELP US TO WORK TOGETHER AS YOUR SCHEDULE PERMITS.

YOU ARE A PART OF BERTHA'S OFFICE. SHE WELCOMES YOU THERE

ALCOHOLISM PROGRAM AT MANIILAQ ASSOCIATION

ALCOHOLISM AND DRUG ABUSE IS DEFINED IN THE STATE OF ALASKA AS AN ILLNESS WITH SIGNS ON LACK OF SELF-CONTROL, THAT THE USER'S HEALTH IS IMPAIRED OR ENDEANGERED, OR HIS/HER SOCIAL AND ECONOMIC FUNCTIONING IS DISRUPTED.

PROGRAM PRESENTLY AVAILABLE OR GIVE SUPPORT IS NORTHWEST REGIONAL ALCOHOLISM PROGRAM INTERMEDIATE CARE TREATMENT CENTER: A 9-BED CARE FACILITY DESIGNED TO SERVE THE ALCOHOLIC AND DRUG ABUSER WHOSE ALCOHOL AND DRUG ABUSE HAS GENERATED A HOST OF MEDICAL, SOCIAL, SPIRITUAL, AND MENTAL PROBLEMS. THIS GOAL CAN BE ACCOMPLISHED ONLY BE ADEQUATE ATTENTION TO ALL ALCOHOL RELATED DISORDERS: PHYSICAL, MENTAL, SOCIAL, VOCATIONAL, ECONOMIC, AND SPIRITUAL. BECAUSE OF THE SEVERITY OF DAMAGE SUFFERED BY THE VAST MAJORITY OF INTERMEDIATE CARE CLIENTS, A THREE PHASE 30 DAY PROGRAM IS AVAILABLE IN THE PROGRAM.

ADDITION: EMPHASIS PLACED ON NANA INUPIAQ POPULATION.

OUR PHILOSOPHY IS THAT ALCOHOL AND DRUG ABUSE AMONG OUR PEOPLE IS MORE THAN A PERSONAL PROBLEM, IT IS A PROBLEM OF OUR COMMUNITIES AND OUR SOCIETY. ALCOHOLISM IS MORE THAN A DISEASE OF OUR BODIES, IT IS A DISEASE OF OUR SPIRIT AND COMMUNITY INTEGRITY. OUR APPROACH TO SUBSTANCE ABUSE RECOGNIZES THAT THE BEST PERSPECTIVE ON TREATMENT AND REHABILITATION MUST LOOK TO THE TRADITIONAL INUPIAQ VALUES, PRINCIPLES, AND VIRTUES THAT HAVE BEEN OUR STRENGTHS AND RESOURCES SINCE LONG BEFORE ALCOHOLISM WAS A PROBLEM.

OUR PHILOSOPHY SEES THE TRADITIONAL INUPIAQ IDEALS OF MENTAL STRENGTH AND REASON (ISRUMA), COMPASSION AND LOVE (NAGLIKTUQ), AND INTERPERSONAL AWARENESS AND HEEDING (IILALIQSRUUTILIQ), AS THE STRENGTHS WE SHOULD NUTURE AND THE GOALS WE SHOULD SET IN TREATMENT. SOCIAL RESPONSIBILITY, PERSONAL MATURITY, AND INTERPERSONAL CARING AND CONCERN ALL ARE PRODUCTS OF THESE IDEALS. THEY CORRESPOND TO THE MENTAL, EMOTIONAL, AND SOCIAL SPHERES OF HEALTH AND ADJUSTMENT.

Kotzebue Elder's Roster of Elders Rresent short meeting 12/2/82

1. Elwood Hunnicutt
2. Fletcher Gregg
3. Lila Gregg
4. Pauline George Rotondo
5. Reuben Towksjhea Sr.
6. Lena Sours
7. Abraham Howarth
8. Fannie Foster Mendenhall
9. Sarah Evak
10. Kenneth Mills
11. George Melton
12. Maggie Melton
13. Carrie Gallahorn
14. Jennie Sours
15. Russell Williams
16. Jacob A. Stalker Sr.
17. Bonnie Thomas

Residents from Kotzebue Senior Citizen's Cultural Center

1. Belle Sours
2. Winnie Divies
3. Benjamin Towksjhea
4. Dolly Vestal
5. May Cleveland
6. Effie Ramoth
7. Topsy Ramoth

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P.O. Box 256
Kotzebue, Alaska 99752

Amy Jones
December 13-17, 1982
Community Organization
Conference Representative
for the
Kotzebue Inupiat Ilitqusiat
Elders Committee
at
Sivunniuqvik Camp

Kotzebue Senior Citizens Cultural Center Elders residents speak on their views and concerns on what they feel will best help our community and region of their topic: Alchoholism and Drug Abuse.

First Elder Speaker: Roscoe Ballot from Selawik, Alaska

It is positive if our support from God remain. that is so necessary in our efforts to stop alchoholism. Today, many snow (traveller) accidents which are alchohol related has become worrysome. Also, transportation of the snow machines into Kotzebue, or in the villages has us worried and experience stressful uncertainties. We want alchoholism to stop in our minds. To the people who are working in our alchoholism problems. it is imperative that you believe in God, be intact as our helper. That is a good positive start for our efforts.

Second Elder Speaker· Belle Sours from Kotzebue, Alaska

I am supportive and voice my endorsement for Roscoe Ballot's opinions.

Third Elder Speaker: Bessie Kowunna from Kotzebue, Alaska

I would like to address the topic of alchoholism, but I am firm in stating that no one will obey (follow) my statements.

Fourth Elder, (listener) Wilson Ashby from Kotzebue, Alaska

(A listener with the elders who were speaking, he had no comments to give at this time).

Fifth Elder Speaker: Winnie Divies from Kotzebue, Alaska

I am willing to help and give my support in our efforts to stop alchoholism. When we recieve God's help. alchoholism, it's been our long past position to stop alchohol. In my mind, I do want alchoholism to stop. Those of you who are involved in providing your support continue ahead. Thank you for working in this area, keep your work going. I know no other way to show my help.

Sixth Elder Speaker: (addition from our last speaker)
Roscoe Bailot from Selawik, Alaska

I would like to add to what I said earlier. It is good (that): I too want to stop the use of marijuana and alchoholism. At Selawik, we call alchohol Tannaq Our grandchildren are mobile because they travel today by snow go even here to Kotzebue, they go unknown without notifying anyone first. Just recently, I had a grand-daughter who almost froze to death. She travelled to Kotzebue with others who came for alchohol. Improperly dressed. she had on one pair of pants. That was such a close call for her. For this reason, I am very supportive of the alchoholism staff's efforts. I am very thankful of the direction that has been shown by the efforts of people against alchohol. It was nice when I was living at Selawik. I would like alchohol to stop there too. I want ot voice my support in this issue, but my words are difficult to surface. It is positive to find help from God, in these issues, God will also help our Elders who are talking to you, We will get help from God. Thank you.

Seventh Elder Speaker: Charlie Jensen (Sagganna) of Kotzebue, Alaska

I know of alchohol: In the 1900's the whalers brought with them their alchohol Inupiaq had no alchohol before the whaler ships arrived. Inupiaq had no fatalities unless there was famine. Alchohol is not good (for us) the Inupiaq. Since I have learned, I have joined the battle against alchohol. The influx of non-native who has smuggled alchohol is increasing. They still come in great numbers (the non-native). The people accept their alchohol.

In our past, the families pursued their game by hunting, that was how the families survived. Alchohol was not their possessions.

As the caribou was needed for clothing and bedding, so were the movement of the Inupiaq hunter's lifestyle. Hunting kept families mobile.

Families took their children with them. They did not stay in a permanent place. I was one of the children which my parents took along that way I learned from them, as we travelled together. The introduction of alchohol at Point Hope was from Attunnauraq, who recieved the whaling ships cargo. Attunnauraq became wealthy as the supplier of alchohol for the people. He also had several wives. He was my uncle who originally came from this area. He is not really of the Point Hope original family. Kuutraatkut Appazzata Kotazzutta Pammiuqtooluum. He came to Point Hope and became difficult to live with. Before he died, he said to my parents to be named. That is what he requested while he was alive. Perhaps it was because he had learned of the Inupiaq who was going after his life. He began to murder his wives because of alchohol. The alchohol source came from him. The Inupiaq who once lived off the land in food supply of the caribou, marine and sea mammal and water fowl. Attannauraq has siblings named

Uyiagaaluk and Tigautchauraq. I knew them. The family members tried to talk to Attunnauraq but he was not listening to them. When he was assassinated his family did not hold a grudge against the killer. That is what we are dealing with here. Because alchohol in Alaska is not okay. Today, we are dealing, as the doctors are too, trying to stop alchohol. (Doctors utilize alchohol as medicinal use). If it is healthy to be used as medicine by the Inupiaq it's okay.

There are Inupiaq councilmen in each of the villages (councilmen overseers). The city council has the policemen as helpers. We can get additional help by the University of Alaska. Unite and band together in your concetrated efforts to control alchohol. Alchohol is bad. It is not good.

The word of God says: We must not forget what God has to say to us people.

People with alchohol problems are not conscious, because they are mixed up like sheep. We Inupiaq are many in number yet we allow our children to get mixed up with foreigners who are not Inupiaq. It is a problem to stop alchohol usage.

Since I got here at 1946, we have had many battles to fight against alchohol. It has not stopped, although, there has been some reduction due to our efforts. I have been at the Anchorage hospiral for a year. There is a big building, they are battling alchohol too. At least in the hospital, as you see other peopla there, you find the alchoholic absent, because radios are utilized to keep things in control.

In the NANA Region, sea coastal villages and Noatak everywhere, our position in alchohol should be equal, once it is there, there will be help. We have leaders in anything that we do to help. Begin your civil rights concerning alchoholism. There is the University of ALaska to help us. Pray about this.

Jesus came to save the lost people from their sin. He came upon our earth to save us, to find us.

As councilmen, get strong by uniting together as one. Include us here.

We were not raised on alchohol. (It has the power) to kill, to burn up.

1902, the Revenue Cutter (servicemen) arrived, just when there was rampant drinking. Qinnikmiut at Point Hope who were (brewing) alchohol when they got there they entered three Inupiaq homes. Present were: Captain Heeley, District Marshall and another worker. Nothing was done to the people. But all the brewing equipment was confiscated and their brew was spilled from the barrels. This happened just when there was a lot of voices you can hear outside by people who had consumed their homebrew. I am not sure about one household who may have hidden their brewing equipment from our three visiting dignitaries. Without alchohol. our place, especially that spring. was very quiet and peaceful. Outside you did not hear anyone crying out anymore.

What you saw were people helping each other at their community house. When the people constructed skin boats, their work was completed in no time., because the Inupiaq helped each other.

The creator of turmoil is based on alchohol amongst our people andthe non-native like this activity of stopping alchohol is beginning You hear them talking about alchoholism now. I would like to see the city council strengthen themselves and unite in their efforts of alchohol.

Searches are now common at the Anchorage airport. Before I was allowed into the terminal, I too, was there where they began searching my bags. I showed them my identification which was about Senior Power, that stopped their search.

People who are travelling into Alaska are under the surveillance which are used at the Anchorage airport.

God will help us. He is one with us everywhere we live.

Alchohol is bad (because it is the cause of many of our weaknesses) like greif and pain. Also the cause of many of our children to be neglected We don't want alchohol. When people with children get drunk on alchohol here, no one is around to look after their children properly.

You have learned of these things by now The city councils should unite with policemen Pay close attention to the alchoholrelated problems and enforce you power to control everything. Unite, Work together to stop bootlegging into our villages. You cannot trust ways alchohol is taken there, especially by uotsiders who are white men, (Just say for example) the people from Germany, they bring things underground. They have infiltrated America and South America.

Eighth Elder Speaker: Flora Penn from Noatak, Alaska

Thank you. I cannot remain calm. I am not strong because of the problems created by alchohol. But I pray for your tireless efforts to stop the misuse of alchohol. Me? I have personally experienced the pain which alchohol has caused in a family I have become very familiar in the effects,

I am very happy to hear of your work in your relation of stopping the use of alchohol and marijuana. The upsetting of a family is grim but it is doubly hard as a parent to suffer. When you cut your hand severely, you can stand it, even if your hand hurts with pain. But when members of family are lost caused by alchohol it hurts. That's painful!

We cannot singlehandedly eliminate our problem with alchohol, but pray. God will take care of our problems which causes pain and greif to all our villages. We must remain steadfast in our belief in God. I am eagerly supportive of our workers in combatting alchohol abuse just so I might protect the safety of my remaining children. That would make me very thankful. Also I am concerned about the grandchildren I have who have yet to grow up. I have always prayed to see that alchohol is stopped. I pray abou the villages to become dry. Thank you. God's power is still present in our land. He can deal with his power and his strength to see that alchohol is taken care of. Because alchohol causes sickness to our bodies also to our spirit, if you remember God, he will help you.

I am willing to be supportive of our people who are working in the alchohol problem My body is weak now. I am not able to be active when I travel - but I have prayed to God for answers to my prayers concerning alchoholism My faith which is attached to God is tight as a rope. I am continuing to tighten my faith through prayers. Do keep in mind that God told us: believe in him, there lies before him his power a way to handle everything. Nothing is beyond his power if he hears our prayers our God will answer them. Thank you

Ninth Elder Speaker: Effie Ramoth of Selawik, Alaska

I want to talk too. Since alchohol's effect is not useful, I am interested in helping too. If possible, we can stop alchohol by prayer. things can be changed by God.

I would like to give an example: Last winter (a while back) I hit a roadblock in my mind, in my thoughts. It was not easy I thought. We were told to pray for the people in jail. Prayers for our relatives were asked of us. In my mind, I thought of the distance of me and the people who were in jail. Then I changed my thoughts and concluded that God does not see things as difficult. So I decided to pray too and join the others in thier prayers. Following a few years, I began to hear that the prisoners that we had prayed for were set free. In reality, God can work even to areas which are beyond us. I thanked my God for having answered my prayers concerning the people I had prayed for.

Here, our people's consumption of alchohol and marijuana has been a habitual thing they do today. But in our belief in prayers for help from God, God does not limit his powers. His unlimited powers can be felt, when prayers can be answered even about impossible and hard areas.

My belief in God has been strengthened by my questioning thoughts at times too. I've remembered my children in my prayers. If trust becomes strong in our faith of God's power, things become tolerable and easy. My needs include the wish I have for alchohol to stop. When people tighten their grip (like the prayers) are attached to a rope and pulled, I wast to join them praying people too.

I want to add strength to their prayers. I am hoping that alchohol will be stopped. In greif, we have lived. Young men hurt us deeply when we lose their lives.

Let us all place our faith in God and work together. I came here from Selawik and joined you.

Merry Christmas! To all of you who are working or facing difficult jobs. God will instruct you and guide you in all lines of your work. God has no limitations if you trust him and pray for his help. He teaches also, gives out intelligence. Floundering in times past. I was not able to understand, my Lord Now he is my master, and God will hear me when I pray to him to help you. Lean on God. The script of his power is on anything, if you remember God. Thank you.

Merry Christmas and a Happy New Year. Thank you.

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ELDERS INUPIAQ ILITQUSIAT PROGRAM

Della Keats gave opening prayer at 1:34 p.m. on January 12, 1983.

Please let us all join together in our prayer's.

Dear God our father, which art in heaven, we have gathered together here to plan concerning our home and community regarding the rejected and reality of our selves, which effects our minds into stupidity especially prevalent among our young people caused by misuse of substances alien to our natural selves. Please grant these smart people with ideas through holy spirit. With the absence of holy spirit - regarding your soothing messages to comfort us - awarness which should accupy our minds - we cannot reject this is why we are asking you heavenly Father, that you are first in our belief. You have informed us, to believe and trust in you. Today we are asking you to hear our prayers for wisdom, erase interferences and grant us what we are asking of you. What we are addressing is a difficult task, only you can make our task lighter.

Bertha Lowe introduced Karen Reeve.

My name is Karen Reeve. We have many different parts to the program so that help can be given and received in ways. One of the ways is that we have a place for people to stay 30 days, and now we are going to making the evenning longer time, to receive help once drinking has becme quite a problem for them. Then we call that a treatment center. We also have what we call outpatient counseling, which is when people come in and see a counselor several days a week, to talk about their problem to look at what strengths can help them to not drink. To get back to a good life. We also have our outreach and prevention part of our program is in five villages now. We now have five village Coordinators. They'll be working in five of the villages now and we hope to have them in the villages. So there's a person to help with alcohol problems and to help the community in what ways that they can in those villages. Hopefully ten villages next year. All also work with the schools, and "Here's Looking At You Program," to help the children learn at a young age on what alcohol can do to the body and hurt them. Just so they have knowledge of it so that they know the facts instead of not knowing what it can do. We also work with the court system very closely. We have a program that is called the Kotzebue Alcohol Safety Action Program. It's with our program. They help people to discover that they or they may not have a problem with alcohol. And we hope with that, we can catch people earlier, before the problem gets too bad. That's kind of our hope for it before it has to go many many many years. So we see quite a few people through there we also work with the Kotzebue hospital, and we help people who are physically getting rid of alcohol from their bodies, and are real sick from it, and we give them counselling and help them look in what might help them in the future. There are several members of our staff here, in fact Charles will you come up here.

Charles Green: No No - sit down. Your're doing a good job. It's good to see everybody, and of course oldtimers that I knew years ago. I don't know if Ethel (Mills) years ago I remembers in a reindeer camp years ago we went out hunting for eggs. Duck eggs. Then she made a cake, that was the first cake I had eaten in my life. I'll never forget it. Taiku for coming. Ahrigaa. I'd like to welcome everyone here with my savagaa (work) Alcoholism. As many of you know it's a problem not only here its a problem all over Alaska and then also down the lower '48 states. It's not among the Eskimo's alone but among Native Americans and the Indian brothers. It's a problem. Ah - I worked in the Seattle Alcoholism program since 1973 at that time there were only two A.A. Indian members in the city of Seattle. Two weeks ago I went to their A.A. meeting where there were 75 Indian people at the A.A. meeting. Now ten years ago there were only two members. And its encouraging. I'm encouraged. And of course when we look, the Alcoholism its such a vast - a strong force. Sometimes you say, "Whats the use?" You feel like giving up. It's like Della Keats, she's there. When she gives up, what are you going to do? Well its the same way we at the Alcoholism (field) feel the same way. A lot of times you get discouraged. Whats the use? I go and get a pick and shovel and get an easier job or something like that. Sometimes we get that attitude. However, when you get ooh - people that are dying of Alcoholism, freezing to death, committing suicide, mental illness, you know alcohol is so - its a strong force. It's not only - its a disrase that can attack the body, attack you mentally, effect your family. Effects you most of all to discourage you. Kill your spirit too. I think the important thing you need to know if you ignore the spiritual, you might not have a chance for recovery.

You might still at six months, two months, a year or something like that after that you can't get rid of it.

From the spiritual - oh - It's so important when you incorporate spiritual into a treatment. The people will have a good chance. Like I told you we'll get discouraged. I'll look at the spirit with people like you coming in here feel like make us feel like going on again. Thank you for proving it and staying.

Bertha Lowe: Are there other speakers? We will begin by allowing you to give your comments. Feel free to walk up to the microphone. If you would prefer not to use the tape recorder, please inform us. I will be taking notes. These reports will be used as our record to help support the Alcoholism program. The Inupiaq Ilitqusiat Program was established with direction coming from you - our elders. Feel free to talk on any topic. If you would consent, we can begin with Lena Sours.

INUPIAQ DAY January 12, 1983 at 1 p.m. MEETING
by the
ELDERS with the KOTZEBUE
INUPIAQ ILITQUASAT PROGRAM
held at the
MANIILAQ CONFERENCE ROOM

Topic: Elders share their ideas on what will best help their community and region on Alcoholism.

Opening Prayer by Della Keats

First Elder Speaker

Lena Sours: My name is Siuyuk, since the time for me to speak has arrived I am very happy to talk again once more. I have discovered how disturbing the effects of Alcohol has been to us. Unlike our image (ourselves), with in the young people of our local population at Kotzebue we have lost a lot of our relatives. Alcohol caused. Many froze and still others kill each other, also seperation of families where a family should really be together alcohol has caused families to be seperated. Family life has been caused to be disrupted because of alcohol. Head of household like parents are not getting adequate rest and sleep. The parents struggle to feed and house their children, the best they know how to handle their alcoholic children even if their children are not helping. When a young working man earns money, the earnings are spent on alcohol. Disregarding his need for clothing, he make. Alcohol has priority on his purchasing power. I want to talk about the things that I have discovered. I am not going to talk half truths, I will be honest in what I have personally discovered. Here at Kotzebue there were attempts to introduce alcohol earlier. Paulluggruak-t-kut-lu (Paul Davidovics) and them became establishments to have liqour dispensories. Including Ferguson's who did open up liquor businesses. Also Itunnurag, several times became a drinking (bar) establishment.

The people in Kotzebue had petitions to keep alcohol out. During this time there were very few white people, our population was dominated by Inupiaq. Many of the Eskimo residents were all Kotzebue aboriginal Inupiaq people at that time. There were no people here from other parts of the State who were living with us.

The people involved in making petitions were ones like Susie (Hunnicutt). We humbly sought to ways for our idea, although many of the people did not treat us well. The people who drank opposed our stand. Yet we continued our efforts disregarding our fears caused by the opposition. Our responsibility was to get names of people on our petition, although amongest us were people who argued. Many people especially parents ignored the arguements of their children and supported our drive (to keep liquor out of Kotzebue). People bravely placed their names into our petition. Our efforts kept liquor from being available and would be turned off. Also we went to the houses with prayers. Your forefathers who lived in Kotzebue actively prayed and were active to keep liquor out. The central theme of their prayers were about their concerns of alcohol. Their risk was to keep a strong stand from seeing that liquor become too accessible. The didn't want alcohol to be here without any control. The elders of Kotzebue would pray by identifying and visiting homes to keep liquor out. Whenever, there was a seed to introduce liquor here our forfathers banned alcohol by their prayers. Our elder's prayers kept out alcohol at Kotzebue. Alcohol was rejected. Our forfathers united their efforts to keep liquor out of Kotzebue.

Later, as you are aware, many outsiders came here. The influx of many new people who moved into Kotzebue has actually changed our population base. This influx of people include non-natives who are white man occupy many homes which you now find today. As many homes as there are now presently standing in Kotzebue they are all occupied. Both the Non-native and the Inupiaq have moved into Kotzebue from all over our villages, all over the country to presently represent our population. I am not talking just to talk against any group of people, I am wanting to accurately portray what I know. I'm not inviting conflict or discord amongst the people. Once many people got into Kotzebue from everywhere it seems that our attitude (from active participation) to uninvalued unmotivated state of our minds has come upon us. Uncontrolled our city now has many outlets of alcohol. Liquor establishments are runned today with no type of opposition or overseers who would inspect the buildings.

(Hand in hand), we are also loosing many lives. Many of our people are dying so frequently now. So many deaths are amongst us today. Especially disturbing times are felt when the outlaying villages have taken a position to ban liquor, and Kotzebue has become a major source of dispensing liquor. Worrisome and unresponsible we have made ourselves by the establishments that presently are outlets for alcohol point to us who reside at Kotzebue.

The heavy dependance of villages for alcohol on Kotzebue is disturbing. We the people of Kotzebue have become numerous. Our present population encompasses other people who have moved into Kotzebue to live here. Let us all unite in our efforts to put the lid on Alcohol and kill it. Why don't you join us because you have become landowners here too, because you wanted to be with us and become people of Kotzebue. Do not oppose our present efforts regarding alcohol. Unite with us to stabilize our stand in what we believe. Let's not fight. Let us join hands to fight against alcohol problems and replace negative impact of our present lifestyle and change into working, helping and caring for each other. Let us move together into a tight knot and oppose the effects that alcohol has on us. Let us join together and unite our efforts into a strong resistance against alcohol. We must pray, talk and walk together in our position as brothers. We can fight against the strong force which cannot be conqured by opposing conditions which has threatened to make us enemies caused by hatred. Instead let us tighten our bond with each other (as a knot would) and unite in love's great power, to redirect the present conditions we are facing in our lives concerning alcohol. Let us all learn to be strong partners who can get along and work well together. Let us all help each other. It's very difficult to face life when unexpectedly a person dies. That leaves us very stunned. I know how trammatic our lives have been whenever we are griefing our losses. Since alcohol has been banned.

Also in regard to villages among our city when the young people earn money they come here and make their parents worry about their absence from home. Since we have become the providers of alcoholic beverages in this region it's not the thing to do. The drink which we are offerring the villages is not a healthy nutritious one to help our bodies. Alcohol which Kotzebue feeds into the village people is unhealthy to our bodies, it kills our bodies, also makes us loose our holy spirit which grarantees lost souls. However we approach banning alcohol will be good. The time is right for us to combat problems caused by alcohol in our lives. We must begin resisting alcohol and control must be excercised regarding it now.

Many times my thoughts have evolved around the concept that the package store sells liquor to their patrons. These same people with money go into the bars for drinks. Liquor traffic is also heavy by people who take it to the villages with them. Liquor and alcohol trafic goes on into villages who are dry or are attempting their efforts to stay dry. If the package stores were closed, the people who are at the bar's would go home without any liquor or alcohol on them. However we approach closing down the liquor stores, we would try to do just that - "close down the liquor stores." We can take whatever stand we can and make our attempts to ban liquor stores. I am not the only person who know about the disturbing effects of alcohol, you too know about the awful ramifications of liquor.

Well we have one way to approach this problem that's by initiating a petition. If we can generate support for our petition we can close the package stores. That's one way of approach I know of. That's the way we can do away liquor and get rid of it. It's clear. There are people who have experienced the concept of opposing liquor at Kotzebue by petitions. I am one of those people. I am talking about the experiences I had in my life, I'm not speculating or second guessing during my speech. But I have talked about the realities of what I have discovered. That's it.

Second Elder Speaker
Susie Hunnicutt

With the introduction of liquor (here at Kotzebue) with spirituality we went house to house with our own petition to keep liquor out, our attempts were futile so we lost. There were people like Mrs. (Edith) Bullock who supported us by suggesting that we keep liquor out. By our informants we were told that alcohol would be had with awful affects on us. We tried to keep liquor out but our position was defeated. We were unsuccessful. "Our first speaker" did not lie, we went house to house, not saving face but by wearing the face of others' amongst disgruntling voices we came thinking of our children. We made our stand known against alcohol, but we did not win. That's the time, as alcohol was introduced we were told that if indeed alcohol becomes a source of our problems, yes indeed, alcohol would be banned and stopped.

Remember that we were promised that alcohol would be banned if it began to be the root of our problems. Well here we are with very few people left among the Inupiaq. Alcohol has taken a large toll among the Inupiaq population yet up to this day, alcohol has not been banned. I am experiencing alcohol in a very bad way. (My husband and I) no longer live in the same house. We no longer are together, (Elwood) is worried of our children who have their own home, because he wants them to live, to survive, he stays with them as their guardian. I also stay with my children in a different house hold where my sons who are young men drink alcohol. At one time some of my sons who were once married they were divorced by their spouses. (My husband and I) do not have an easy life. You don't know it. With love for our children it is very diffult as a parent to live like that. Those of you who are without children do not know our experiences. When you love your children, and their lives (revolve around alcohol) I've discovered how much hurt is involved in one's life. People have noticed our lifestyle, because they talk about us, but that is the way we are dealing with our family and living with our children. Whenever they earn money, it is wasted and used for their habits which to them is fun.

I have tried to stand living the type of life I am describing, yet whenever I couldn't stand the situation many times I have given them over to the authorities. Even the authorities are helpless in handling the case of my children. Last fall as I again handed over a son, my thoughts were that he wouldn't live much longer, if he continued life at the rate he was into alcohol I was at a meeting with one of the authorities until it was 11:00 o'clock. There were very few people around us.

Alcoholism has gripped a young man. There was a scholar, and "Flo", his boss from the hospital. Including an authority we had a meeting. I tried to speak about my rights concerning my son, yet the authority didn't do anything for me.

Perhaps they had no evidence against me, perhaps I should have been put into jail. Our meeting centered around our talk that everything would be better if alcohol was banned. This response was how can alcohol be banned, there are no laws concerning alcohol (in Kotzebue). As I listened to the response of the authority I questioned previous positions which was made known to be. For example, Hensley. The fall before last (1981) he spoke to me and said, "Uou who are Inupiaq Unite." Take a united stand to back up a petition and alcohol will be banned. Alcohol can be banned from Kotzebue. I was told that by Hensley in person. After talking with Hensley, I'd bring up our conversation regarding alcoholism but my friends did not respond.

Perhaps I've not received a response from my friends because they have good children. They are not experiencing life like I do. The trauma which I am living is a hard life and I am getting weaker to put up with it much longer.

If we want to ban tobacco, we've been told that alcohol can be banned. The home of the Inupiaq is Kotzebue. It's the land which is owned by Inupiaq. Presently landowners are not the white men. I am not talking against the white man. That's not the intention I have within me. I am speaking mainly to ban alcohol, as my purpose. We have been informed that alcohol can be banned if you take a united stand on doing so. If alcohol becomes the cause of our problems we have been told that alcohol can be banned. That's been their stand.

Yet in reference to an authority when alcohol was introduced here we have been told that alcohol was okay. It was okay, is what (he) said. Upon my son's return home he went back to his old lifestyle but today he seems not to be so bad as he once was. Maybe he's keeping his head this time. At least he's acting more sober, and has a job now. He has injured himself before like breaking his leg.

If you love your children, resist and reject it. If you reject it, sign against it then alcohol will be removed. Our city is embarressing when people's children come here from their villages. As each of you are talking too, its terribly disturbing to see lives lost before they return home. These traumatic experiences which we are exposed to in our lives shouldn't put us through such a life, what you need to do is reject it.

The people who want to consume alcohol can return to their homes with their alcoholic beverages and do so. If all of you unite as one you can remove (alcohol).

I also know about many of my relatives who have many sons, I know what we have gone through, tough experiences. Hard lives we've had to go through. Including our daughters, even if you love them whenever they make you go through these time of hardship it's painful. Thats it for me now.

Third Elder Speaker
Ethel Mills

I am happy also. I am happy that I didn't leave today. "I'm so thankful I never go today. I'm supposed to go to Anchorage hospital tomorrow, and I'm glad I am here with you people, to discuss about this alcoholism. Yes its true, what these two elders was talking about. We moved down here back in 1963 because my husband is from Kotzebue, we moved down here to be with our children because they come here to work.

Where they can work, and we helped these elders, when they go around the houses to let them sign a petition. And at that time there's no liquor stores, because they were fighting I know. I was with them too. I went around with them. We went to all the houses. This side and some of us go down that way. From our church, Parisho, was the one that started us. Againsting alcoholism. We had to go to every houses and ask the people to help us. They did. Even the drunkards were glad to have us., They said they know that alcoholism is not good for anybody. And we were glad to do it. I was glad to help them too. And one time when I went over to Nome for the church. Some churches had conference and they discussed things that were not helpful to them to the people. One was alcoholism.

And when they talk about it, I think about this verse. It's in the bible. But I forgot the reference. "Wherefore, lift up your hands, which hang down." Something like that. "That means do something" You know when we hang our hands down that means we don't do nothing. But when we lift up our hands and try to do something. That's the time we do something. We work. And that's what I had in mind. when they had those conferences in Nome for four days. I was one of the observers. And when they talk about alcoholism that what I had that verse. And when we go back here and when they asked us what we were doing over there. I mentioned that. One thing about alcoholism I want to tell you people, "If we never try to do anything to go against alcoholics, that's what we should do like that verse said. "Lift up your hands and try to do something to help go against it." and it was good. Also our children, they were drunkards and our grandchildren will be the next one. They'll be worse then our children. It really hurt my heart because I know if we never try to do something, our grandchildren will be worse then our children. My children were drunkards. But I'm glad some of them quite drinking. It sure is true that these people talk about it. It really hurts. And ever since I start praying about it and when they had those youth centers I was thankful. Because they try to help those youths to keep them away from the alcohol - Alcoholism and marijuana too. And I was really thankful for that. Anything - and when I heard about this I rally want to come.

Because even just coming in here, that shows that I'm againsting it. And tell you the truth that we are hurting inside. Because we love our children; our relatives. Our cousins children, our grandchildren we love them so much, we don't want them to have kind of thing, that hurt their bodies. When I was little girl back in 1918 we heard that there is a big flu coming this way. And people - so many people died. And people around here start praying. They don't want that flu to come here.

Because they gonna die, leaving just children. And I remembered those people really prayed for it. And it never get here. The lord answered their prayers and that flu never come around. And there's nothing that is too hard for the lord. If we only prayed earnestly from our hearts, and do something that really will work out. I know the lord will really help us. And it really hurt to see other people when they lost their loved ones young people, that are not sick. It's terrible, and I'm glad I can say a few words here too. That I'm againsting it.

Fourth Elder Speaker
Della Keats

Whenever there is a meeting planned here, the people are meeting about a topic I personnally abhor. Whenever, you meet people they hesitate to speak up. Well I'm next as your speaker now. I came up right away. Whenever, people are slow in their participation they are looked upon as callossed.

Today I travel concerning the aged, I travel into many cities. I have travelled into many other places. I too from the beginning has been aware of Alcoholism as a topic for our meetings as least up there at our home (Noatak). Because alcohol was absent. I grew up not seeing people who drank. It was much later, that I joined the people here who worked with Mr. Becks at 1963 in their efforts locally against alcohol. Mr. Becks organized our activities, because he didn't approve of the effects of what alcohol would be if it were to become available here at Kotzebue. We did not agree to have young people to indulge in alcohol. That wasn't acceptable with us and we opposed it. We took names of people to oppose alcohol. Once we successfully won and kept alcohol from being introduced here at Kotzebue, that's when I moved here in 1963. I moved into Kotzebue in 1963. My Aunt (Aulagsrauq - Curtis) and I - "Lena Sour's older daughter.

Whenever (Aulagsrauq) uncovered topics for a meeting she came to me before we moved to our present addresses. You remember the area where our homes were once located, Mrs. Curtis came to me before we moved. During our move into our present location. She was also my neighbor. We were like partners yet she was also my informant on what meetings would cover as upcoming topics. These two elders are speaking the truth. They have always been our older residents of Kotzebue. They are taking about the actual situations they saw. Our city population was dominated by Inupiaq people. Very few non-native like white men and black people were here.

At one time we had very few white people amongst us. Staggering people dependent on alcoholism type of problems where absent. The two previous speakers are telling the truth. With introduction of Alcoholism we began to hear people who would talk about liquor establishments that the small populated white people wanted to introduce here as a way to make money. I know what the earlier efforts were like to keep alcohol out. Since we lost twice I signed (the local petition). We signed the petition which they took into Kotzebue but we lost.

Alcohol seem to be out of hand - uncontrolled and forgotten - when we lost, I joined in their local efforts to keep alcohol out because I wasn't for it, and I am terrified of it. I'm not a person who accepts alcohol on television or outside when I see anyone staggering from affects of alcohol. Whenever I see people outside my home who is drunk and staggering, I am always locking my door because I don't want them entering my home. I am a petrified scared old woman.

My children and grand children are heavy alcohol consumers. They drink a lot. I don't like that. This morning I just talked about that too. Here I am again talking on our topic of alcoholism which isn't good. We are loosing a lot of our people because of alcohol. Alcohol is the cause of many deaths of our young people. Young people are dying, even the ones who can live longer then we the elders.

Our younger generation of the Inupiaq are dying of alcoholism not of sickness or related to illnesses. They are leaving us at a very young age. They should live longer and pass their life expectancy. Disregarding life our young people plays with their lives, they only mock their being. Their bodies. Another thing which they abuse on themselves is marijuana. They are smoking the filthy ugly marijuana. Wherever you go in all the villages and cities you see people everywhere smoking marijuana and drinking alcohol. There you see the head and brain of our people rotting and wasted. Many of our young people can kill himself. They continue to kill themselves. You have a job which is a very bad ugly field of work. "You people who work for Alcoholism is - ooh - good." Is ooh good, for us not to have it, all the time to our grand kids. Great great kids.

Their work against effects of alcohol is very strong among our school children. It's an effort which you are working on to weaken the alcohol to kill the use of alcohol among school children. Their trying to defeat their battle against alcoholism, that's why we were called here together for his meeting. Why are you refusing to talk about Alcoholism now?

Give everything to God - when you do nothing is difficult. Give everything to our God. If we unite, please take away the roadblocks and obstacles on this topic to keep our way clear of interferences. That is the position to take so our God can grant us our prayers. Your wish will be granted with Gods help. The Inupiaq before us have successfully banned alcohol by their prayers. Our forefathers kept control of alcohol by their humble prayers.

Our present circumstances seem's as if we are drowsy. We act as if we are sleepy today. Not fully awake is the kind of a position seem to be projecting - such contrasting attitudes of ourselves. It's with feelings of graditude and heartfelt thanks that I was so thankful when they called me too. I never even eat my lunch. There's lunch for me alright but I want to go to this meeting. Cause I've never been to an alcoholism meeting. Boy! if this - however possible way - if we can ban alcohol which is our present outlets. How can we stop the sale of alcohol? We can stop the use of alcohol, or alternatives will crop up especially if we discover that alcohol is a topic beyond our control, let's look into shortenning the hours that alcohol is available.

It's embarressing when the villager's experience disasterous accidents on the waters (drowning), or freeze to death (on land). Their disrespect for their bodies - for their lives is very bad beyond any kind of help - its so awful to find oneself in that position on a Alcoholism.

An alcoholic I was working on did not survive. I was unseccessful in treating an alcoholic. I was helpless. It was difficult to let go. It was sad and such a lonely position to accept death for the alcoholic. It's so sad even to stop administering the little care I could give. What was even more difficult was to inform my dead patient's parents. I wanted to break the news of their child's death, but it was within myself that I kept the burden. I kept the bad news and pain with myself.

I have not succeeded in talks with my alcoholic clients condition. They pass away before I can talk to their parents. I could share the painful message with my patients alcoholic conditions which are usually beyond help, but I never get around to talking to their parents. They die because they are out of helps reach.

You have a good helper - the faithful workers are now amongst you concerning this problem. Presently you will hear efforts that are going on today against marijuana you hear it whenever you travel outside of Kotzebue. These life conditions that we are facing add to our cause of illness because of the presence of alcohol. It's everywhere. Our workers who are dealing with this, we who are elders are pointed at. We are accused. We are blamed those of us who are elders they are pointing their fingers at us and calling on us to hold this meeting. They desire a way to say that is the decision of our elders are these thoughts. In the future I hope we will be remembered of our decision because we go together. We united.

Our speakers have addressed their concerns for their grandchildren to hear. I too love my grandchildren. I love my children dearly too. I don't have as many children as some of you. I have three children. Two of my present children and all of my grandchildren are into alcoholism. That is their way of life. Individually if we show concerted efforts aginst alcohol, that is okay. It is okay.

If our efforts to oppose these problems are remembered in our prayers - our prayers will be answered. God can hear our prayers.

Many times I have turned to prayers where I was helped by such prayers. Our God knows no boundaries, not even difficult areas that we are tackling with.

A great leader regardless of the leaders position that is - that a leader rules, God doesn't hesitate to excercise his powers on anything.

If we all unite and go forward with our decision God knows no limitations of his powers. God will work for us. Accomplishments in our work will be shown by God.

In arguments, in disagreements if we go aginast that person (or a person) thats not the right approach. We are all working for ourselves. But let us bring up this topic and our concerns to our God. Truly believing in our God, if we ask for help believing in him. God answers prayers.

There are many other speakers who are present at this meeting. I've talked a lot for now.

Walter R. Meganack Sr.
Port Graham Village Council
Port Graham, Alaska 99603

May 27, 1983

Mr. Mark Andrews
United States Senate
Select Committee on Indian Affairs
Washington, D.C. 20510

Dear Mr. Andrews:

Monies spent on health is a very good investment for our being a strong nation. Therefore I would like to see that the Indian Health Care Improvement Act continue with these changes or additions:

1. Allow local level policies decision.
2. Allow more communities- Health Aide Training.
3. Allow more decent salaries on health aides.
4. Make more facilities and equipment available locally.
5. More personnel training.
6. Upgrade delivery service systems toward local and in accordance with community needs.

The above is my essay.

Sincerely,
Walter R. Meganack, SR
Walter R. Meganack Sr.
Village Council President

cc: Dick Rolland, NPR
Julie KitKa

NANA REGIONAL CORPORATION, INC.

GOALS OF OUR PEOPLE

NANA is the instrument through which our Inupiat People not only achieve economic objectives, but more importantly protect our LAND. The Board of Directors, as elected leaders must assume the responsibility for the Inupiaq Way, as expressed in our language, traditions, history, values and culture. Our primary goal must be "INUPIAT SURVIVAL".

Inupiat Ilitqusait

The Inupiat people have endured for countless centuries in a land that required total concentration on survival. Our harsh environment created a people full of commitment and cooperation - people with a strong spirit, a strong mind and a strong body. The goal of Inupiaq survival is expressed through Inupiat Ilitqusait - a program of life which hopes to maintain Inupiat control of NANA after 1991 as well as to provide for the rejuvenation of Inupiaq Values. While the values are traditional and ancient - we believe that these values will help guide us as we plan for the future.

The Key to Inupiaq survival is a strong sense of identity and well being as a Inupiaq and an understanding of the key values of the Inupiaq as well as the spiritual continuity expressed through our language, family, traditions and history. Inupiat Ilitqusait will help us individually to have a sense of direction as well as to provide a bond for leadership that ties us to our people and our land.

It will provide a philosophy that can be used to measure all western institutions that have been provided for our use. Inupiat Ilitqusait can help us make better use of the political, economic and educational systems in our Region and State. The basic principles which will guide NANA in the future are:

1. Every Inupiaq is responsible to all others for the survival of our culture, its values and traditions.

2. Through our extended family, we retain, teach and live our Inupiaq Way.

3. Elders are responsible for the transmission of traditional values and skills as well as guidance in their daily use.

4. Inupiaq is the language through which cultural identity, traditional values and skills will be transmitted.

5. Our land is the physical symbol of our combined Inupiaq spirit.

6. Our understanding of our universe and our place in it is our belief in God and a respect for all his creation.

The following values will guide NANA's conduct:

humor, sharing, humility, hard work, spirituality, cooperation, family roles, avoid conflict, hunter success, domestic skills, love for children, respect for nature, respect for others, respect for elders, responsibility to tribe, knowledge of language, knowledge of family tree.

NANA REGION GOALS

1. To instill Inupiat Ilitqusait as the guiding philosophy of all Inupiat in the NANA Region by:
    - A. Insuring that Elders provide advice, leadership and training.
    - B. Providing Inupiat Ilitqusait programs in each village.

C. Urging all parents, grandparents and relatives to teach their children Inupiaq as well as traditional skills.

D. Using Sivuniigvik as a center to promote Inupiat Values and skills.

E. Implementing Inupiat Ilitqusait in all major institutions serving the Inupiat of the NANA Region.

F. Developing an educational foundation that will assist in carrying out the objectives of Inupiat Ilitqusait among our young people as well as to help prepare them for Western job skills - in our Region.

II. NANA will pursue continuation of the merger program with Kikiktagruk Inupiat Corporation.

III. NANA will actively encourage and assist individuals embodying Inupiq Values to participate in positions of responsibility in the NANA Region.

IV. To encourage shareholders' and employees' participation in the political process, NANA will create a Political Action Committee. (PAC).

NANA will encourage the state and federal government to consider Inupiat Values in the management of their lands.

MANIKPUT (Our Money)

The Capital (money) of NANA is also a survival tool. It can be used to protect our land and our people.

NANA's goal is to use our capital to maintain a profitable corporation - for if we do not, we will ultimately lose our land.

If NANA's capital diminishes, our power will lessen and make us vulnerable in many ways. While NANA recognizes the importance of dividends, we must also keep in mind the need for capital growth to create more jobs and to protect our lands.

NANA's goals are:

I. Maintain profitability.

II. Provide for capital growth as well as dividends.

III. Establish a shareholder survivor benefit plan.

IV. Urge shareholder training and hire by other institutions.

V. Establish a shareholder management trainee program.

VI. Establish marketing of traditional crafts and food.

VII. Develop an employee retirement system.

VIII. Encourage and support self-sufficiency in each Inupiaq family.

INTER-REGIONAL GOALS

NANA's statewide objective since 1966 has always encouraged unity among the Indians, Eskimos and Aleuts.

The economic and cultural well being of the other Regional Corporations is vital to our future security.

NANA's goals in conjunction with other regions are as follows:

A. Encourage cultural identity and pride in each Native Alaskan.

B. Urge establishment of Spirit Programs in each region.

C. Achieve mechanism to establish shareholders status for each Native.

D. Encourage merger of Village corporations with regions.

E. Establish education systems that recognize traditional values as well as developing a competent student.

F. Encourage the establishment of enterprises which enhance the economic and political strength of Natives.

G. Encourage public understanding of Inupiat Ilitqusait.

Response to Recommendations made by the IHS Task Force on Proposed IHS Service Policy Changes

Presented to

Select Committee on Indian Affairs

Mark Andrews, Senator, North Dakota, Chairman

Date: June 1, 1983

Prepared By: Elise Sereni Patkotak, Director
North Slope Borough
Health & Social Services Agency
Barrow, Alaska and Chairperson
for the Association of Regional
Health Directors of Alaska

This testimony is presented on behalf of Alaska's Twelve Regional Health Directors.

This report should be considered significant due to the fact that the Twelve Regions and Alaska Area concur in all substantive issues.

Section I

FORWARD

The policies, organization, and information systems of the IHS have not kept up with the pace of the rapid growth and change which the IHS has experienced. Problems have resulted from this inability to keep up with the pace of growth and change. Further, our review of the Task Force Report would have been much more positive and productive if the Area and tribal level would have had an outline of issues and concerns with which the IHS is faced presented to us in a framework for suggestions on resolution of issues and problems. Since this was not the case, but unfortunately is standard operating practice when I.H.S. directive's are imposed, the natural reaction of the people at the Area level and the tribal groups was and is to react to the negative aspects of the Report and to the directives which are considered onerous. As a result, this report focuses on issues which are unanimously unacceptable to the Alaska Area and the Alaska tribal organizations.

One of the first things that became apparent when the Alaska Task Force met on April 18, 1983 was the IHS Task Force was misnamed. While its focus may well have been limited to Contract Health Services originally, as acknowledged in the Director's Report, the Task Force was allowed to broaden its consideration to a general consideration of the IHS delivery of health services system in general. We feel it would have been less misleading to have renamed the IHS Task Force a Task Force on Improvements to Program Management.

Section II

Clinical Priorities

The proposed scheme of clinical priorities represents a major change from existing IHS and Alaska Area philosophies. It is totally unacceptable to the Alaska Area and the tribal groups it serves. If the Task Force recommendations are allowed to become policy, the result will be that the IHS attains the lowest possible level of health care for the Indian and Alaska Native people. This would result from the Task Force desire that all direct health care facilities of the IHS be equal and that none provide services which are unavailable at another. Obviously this destroys a logical, well-accepted system such as exists in Alaska where local (village), regional, direct in-patient facilities have a basic community hospital capability but also have the ability to refer patients to a tertiary care center within the IHS system i.e., the Alaska Native Medical Center. This concept of progressive delivery of care through various levels of intensity has probably done more to improve and maintain the general health status of Alaska Natives, at a much more reasonable cost than could have been attained had IHS tried to purchase all tertiary services through the Contract Health Care Program.

The Report specifically calls for the discontinuance of the broad range of services available at our medical center. It disregards the concept of a medical center as a referral facility which offers certain services that the referring hospitals (small bush hospitals in the Area of broad service region), because of their small size, cannot offer. The Report proposes a lowest common denominator theory which would reduce the level of services at ANMC to the highest level available at the smallest of its referring facilities.

Few, if any, physicians or other health care professionals would be satisfied to function under such an artificially established care program which would refuse lifesaving or restorative care to individual patients. Morale would hit a new low, pride in the IHS program and system would totally disappear and with it a cadre of physicians and other professionals who would find no professional stimulus, nor pride and no chance for professional growth. Recruitment into this type of program would be difficult and retention impossible. One can easily visualize that eventually the program would be staffed by locum tenens and other temporary physicians rather than a professional dedicated medical staff.

We do not disagree that public health and preventive measures impact a great number of people. However, the individual impacts of little or no coverage with respect to basic acute care services, which are standard throughout the medical care practice world, give no support to the Indian Health Service recommendation to refuse to provide basic and acute care to its beneficiaries. Such a step would represent a calculated regression in the level or service commitment to the Indian population.

The Alaska Area and Regional Health Directors (RHD) strongly feel that as citizens of individual states. Indian people are entitled to the same level of public health and preventive services as is available to other citizens of the state in which they reside. If the Federal Government chooses to give category A, as presented in the Report, its highest priority status, what would prevent a state, such as Alaska, from reducing its level of commitment to public health and prevention now that the Indian Health Service's number one resource commitment is for these services? The Alaska Area Native Health Service feels that the proposed category A should have equal priority with the proposed category C plus certain professionally determined category D diagnoses such as cancer chemotherapy, neonatal intensive care, and coronary bypass procedures. While some recognition must be given to the fact that States have no obligation or provide proposed category A services on a reservation, the basic access to these services by "non-reservation Indians" to State programs must be recognized in the distribution of resources.

To illustrate the concerns about eliminating the provision of what has come to be basic health care services we would point to the proposed restriction to neonatal intensive care. As proposed, the restriction would be feasible only if the non-IHS tertiary center would agree to provide care knowing the IHS would not pay. This would mean that the IHS would be going back two decades in the approach to high risk maternity/neonatal care and would be proclaiming their intention to ignore perinatal mortality/morbidity as a goal - ignoring both, from a medically acceptable basic service and by ignoring the trust responsibility to a particular segment of the American society.

This proposal is contradictory to what IHS has come to stand for over many years of service to Indian and Alaska Natives.

Concurring with Alaska Area, we strongly feel that the planning and directing of resources, including the setting of clinical priorities is a local responsibility. Likewise clinical decision making must be locally made. The Task Force recommendations carried to its extreme, including the use of fiscal intermediaries, could mean ultimately that clinical decisions, including life and death clinical decisions, would be made by someone performing a clerical function through the use of a listing of disease entities resulting in decisions such as "I AM SORRY Mrs. Matu, your son has leukemia, cancer treatment is not on our list so we are prohibited from treating him".

Such decision making is contrary to all that the Indian Health Service has come to represent: local, individual need based, clinical decisions made in the context of broad program requirements and directions, not nationally imposed detailed lists which have originated out of fiscally motivated instincts.

Section III

Eligibility

The RHD's accept the recommendation that eligibility for direct, contract and IHS supported tribal programs should be equal. Please note our slight but significant qualification. The IHS cannot dictate to the tribe who they may want to serve i.e., Indian people who may not be eligible for IHS programs. But IHS may limit the reimbursement for those persons not eligible for their programs.

Unanimous concern was voiced regarding individual tribes deciding who is an eligible Indian person for purposes of IHS services. This is seen as possibly compounding an already difficult problem with respect to some tribes who have indicated that anybody who can demonstrate Indian heritage should be considered eligible, while other tribes would limit eligibility to a specific degree of Indian heritage. For the purpose of determining resources with formulas based on population numbers, it is obvious that a tribe with a more restrictive eligibility requirement would be penalized merely due to lesser potential eligibles than one with broader eligibility requirements.

Alaska tribal groups believe that the IHS should take the lead in establishing who is eligible for IHS services. In such a process the IHS would limit who then could enroll for IHS services. The Alaska Area and RHD's do not want the Indian Health Service to be involved in or duplicate any of the functions which are properly the responsibility of the Bureau of Indian Affairs, such as assistance with and maintenance of tribal enrollment records.

In this regard the Alaska Area Task Force finds the use of the term "blood quantum" to be distasteful. We feel some effort should be made to de-emphasize the focus on degree of Indianness while recognizing that some basic criteria related to heritage must be utilized to determine who should and who may not receive services through this special program known as the Indian Health Service.

Section IV

Impact on P.L. 93-638 Contractors

Since the Task Force broadened their considerations to include delivery of health care services by IHS in general, we are quite disturbed to see that the IHS Task Force did not include any 638 contractors let alone anyone with real 638 expertise. 638 contractors were instead swept into the collective of those who may be imposed upon to make operational and management changes to comply with Task Force recommendations. This is not necessarily a correct assumption. But it underlies the recommendations throughout the report. The report states "the Task Force's recommendations address fundamental issues involving the delivery of health services by IHS and by tribes which operate programs under contract with IHS." This statement assumes that recommendations which would result in the beneficial change to the IHS operations can be imposed on the tribes who are currently operating health facilities under a 638 contract and that the recommendations would eventually result in a beneficial change in tribal operations as well. This in fact is not true. Tribes are entities separate from I.H.S. They provide broad ranges of services for their populations. IHS Health care is often one of many contracts and grants administered by the tribe. Tribes have developed internal operating procedures and respond directly to their boards. It is important that IHS realize tribes are not an extension of Indian Health Service, they are non profit Corporations that are responsive to local needs and contract some programs from IHS.

It is felt by many in Alaska that the imposition of nationally formulated policies, with little or no local input is contrary to, and flies in the face of, the philosophy and intent of self determination as expressed in P.L. 93-638.

Section V

Additional Concerns

1. **Task Force Membership:**

The IHS Task Force membership did not include any practicing clinicians. Since many of the recommendations would restrict a health professionals ability to serve his client, this omission is glaring.

2. **Improvements:**

Under the discussion of Need for Improvements, a significant item was overlooked. Much of the IHS problem with management of its resources in a logical straight forward fashion is due to late Congressional action on agency funding. When an agency, such as IHS, is restricted to the fiscal appropriation for the year in question and does not have the ability to receive appropriation for offsets in subsequent years (unlike other federal health care delivery programs i.e., the VA and Medicare) a basic flaw is created by the lack of an accurate operational budget until late in the fiscal year. This in itself prevents consistently good management. For an example of the inconsistencies and logic breakdown throughout the report, one need only turn to statements made under "Federal-Indian Relationships" on page 5 where it states that the "IHS has a legal and moral commitment to preserving the relationship between IHS and Indian people" and contrasting that statement with the statement following the quote from the Snyder Act on page 2 which indicates that "this language establishes IHS as discretionary program not a program entitling eligible Indians to specific services". If there is a legal and moral commitment how can it be discretionary?

3. **Terminology:**

There were no significant difference with the Task Force regarding the recommendations under Terminology.

4. **Planning and Management:**

We agree and support the recommendation that a "reorientation of IHS resource and patient management is required, one that shifts IHS present emphasis on the retrospecitve management to the prospective planning and management by IHS clinicians and local administrators of patient care" with the notation that this is a recognition of the value of local input and direction. Unfortunately what follows in the balance of the Task Force report indicates strong direction and mandate from the national not local level. In fact the next part of the Programmatic Reorientation section recommendations not only speaks to involvement of "higher Departmental and Congressional levels", but by virtue of the time of the report indicates that this is where the direction will come from. The other part of this second recommendation could be accepted with qualifications; we cannot endorse "both IHS and tribal programs (being) accountable to the same standards of administrative performance" until the standards are defined.

5. Clinical Resources Allocation:

The new formula proposed under Clinical Resources Allocation will not solve what is intended by the recommendation. Among other things the formula is unable to take into account one of the critical elements that the Task Force focused on "d": unique geographic, economic, and health status characteristics of service areas - a most key factor in determining an equitable distribution of resources. Further,the use of hospital and ambulatory care service encounters of previous fiscal years may be limited by resources available during that year and may not be a reflection of real needs. Level of staffing, available space, availability of beds and related staff and patient access can all artificially restrict utilization of services and have done so historically. Estimating needs on the basis of utilization during previous fiscal years can be dangerously misleading. The subtraction of previous years resource collections is a negative incentive; in the past IHS has been promised no reduction for efficiences of collection of all other resources but has subsequently been penalized through reduction of its allocation on the basis of potential, collectable resources. This factor combined with the negative incentive to the patient himself, if the Indian Health Service refuses to meet the deductible for needed referred acute services, will lead to patients dropping third party of alternate resources and thereby defeating the purpose of the formula. Again,the idea expressed by the formula is a good one. All of the IHS areas including the Alaska Area recognize the flaws and problems with the present method of distributing resources on a so called equitable basis. What is proposed however, will only perpetuate what has already been described by the courts as a "bureaucratic sham".

6. Medicare reimbursement:

The Task Force recommendation regarding reimbursement of providers under Medicare rates and methodology represents a rather simplistic view of how the Medicare program works. It also presupposes many issues which may not be legally possible. In Alaska a majority of the providers will simply not accept reimbursement on the basis proposed thereby negating the possible effects of a third party resource that the IHS would be counting on. In Alaska there is an overall shortage of physicians and those physicians for the most part are able to pick and choose patients whom they treat. Private insurance in Alaska is extremely generous and reimburses physicians at a full billed rate or very near to it. Many physicians in the Anchorage area already refuse to treat patients of any ethnic group who are Medicaid eligible and they refuse to accept assignment under Medicare. They have no economic incentive to do so. If IHS were able to impose Medicare rates, the differential cost will merely be shifted to someone else i.e., the non-Indian, full pay private patient. This has the risk of further alienating from society at large, the Indian person.

The Alaska Area feels that it can accomplish the intent of the recommendation made with respect to Fiscal Agents without the additional expense of fiscal agents. They believe they can demonstrate that the IHS can make upduplicated payments while coordinating all third party resources at a cost much lower to the government than would be the case with the employment of a fiscal agent. IHS Alaska Area is prevented from immediately implementing this only by virtue of the artificial constraints placed on their management ability by the fact that they cannot match their locally based computer assisted capability with the management problem in question. While elements of a basic system are available through the PCIS and CHS/MIS, these need to be cost justifiable.

Section VI

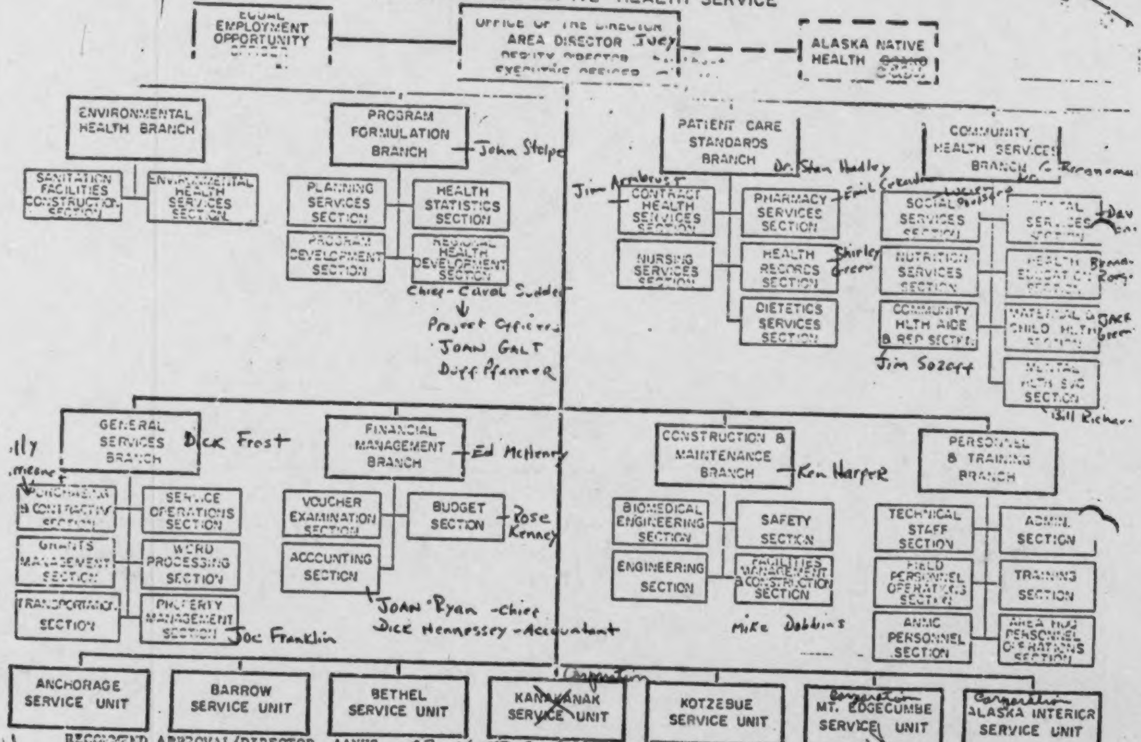
Summary

Again we wish to emphasize that we recognize that the overall managment of the Indian Health Service Program needs to be improved. However, this should not be at the expense of destroying the basic system of health care which has been established over the last 20 years and which functions basically as a model program which embodies the concept of regionalization and referral through levels of care all of which are basically within and under Indian Health Service direction.

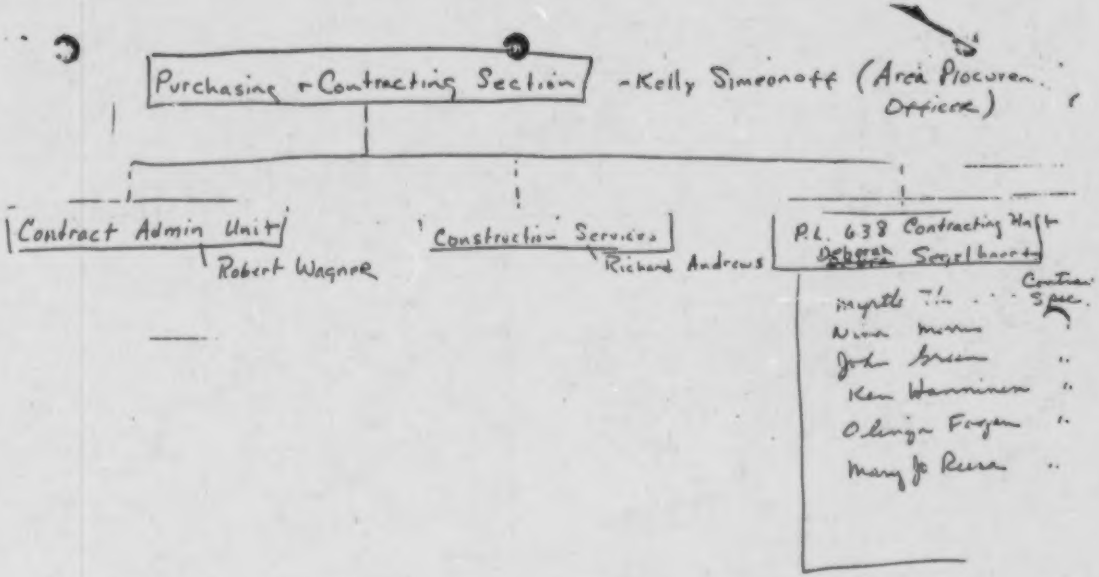
We feel the basic philosophy as expressed in the Task Force Report will negate the progress which has been made by the Indian Health Service with respect to the health status of Indian and Alaska Native people. However, we, along with the Alaska Area Native Health Service, wish to express our honest willingness to explore further how the management of the Indian Health Service program can be improved while maintaining and further improving the health status of the Indian and Alaska Native people.

Alaska Area has stated that before they could fully support the Implementation of any of the recommendations of the Task Force, as well as the ongoing Evaluation of that implementation, further honest input must be solicited from the operational i.e. service unit/area level.

DEPARTMENT OF HEALTH EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE
ALASKA AREA NATIVE HEALTH SERVICE


Cary C.
EQUAL EMPLOYMENT OPPORTUNITY OFFICER
OFFICE OF THE DIRECTOR
AREA DIRECTOR Jucy
DEPUTY DIRECTOR
EXECUTIVE OFFICER
ALASKA NATIVE HEALTH ~~BOARD~~
ENVIRONMENTAL HEALTH BRANCH
SANITATION FACILITIES CONSTRUCTION SECTION
ENVIRONMENTAL HEALTH SERVICES SECTION
PROGRAM FORMULATION BRANCH
John Stelpe
PLANNING SERVICES SECTION
HEALTH STATISTICS SECTION
PROGRAM DEVELOPMENT SECTION
REGIONAL HEALTH DEVELOPMENT SECTION
Chief - Carol Sudder
Project Officers
Joan Galt
Duff Pfanner
PATIENT CARE STANDARDS BRANCH
Dr. Stan Hadley
Jim Armbrust
CONTRACT HEALTH SERVICES SECTION
NURSING SERVICES SECTION
PHARMACY SERVICES SECTION
Emil Colando
HEALTH RECORDS SECTION
Shirley Green
DIETETICS SERVICES SECTION
COMMUNITY HEALTH SERVICES BRANCH
G. Reconomu
SOCIAL SERVICES SECTION
NUTRITION SERVICES SECTION
COMMUNITY HLTH AIDE & REP SECTION
Jim Sozoff
DENTAL SERVICES SECTION
Dav
HEALTH EDUCATION SECTION
Brenda Rong
MATERNAL & CHILD HLTH SECTION
Jack Green
MENTAL HLTH SVC SECTION
Bill Richar
GENERAL SERVICES BRANCH
Dick Frost
PROCUREMENT & CONTRACTING SECTION
GRANTS MANAGEMENT SECTION
TRANSPORTATION SECTION
SERVICE OPERATIONS SECTION
WORD PROCESSING SECTION
PROPERTY MANAGEMENT SECTION
Joe Franklin
FINANCIAL MANAGEMENT BRANCH
Ed McHenry
VOUCHER EXAMINATION SECTION
ACCOUNTING SECTION
Joan Ryan - Chief
Dick Hennessey - Accountant
BUDGET SECTION
Rose Kenney
CONSTRUCTION & MAINTENANCE BRANCH
Ken Harper
BIOMEDICAL ENGINEERING SECTION
ENGINEERING SECTION
SAFETY SECTION
FACILITIES MANAGEMENT & CONSTRUCTION SECTION
Mike Dobbins
PERSONNEL & TRAINING BRANCH
TECHNICAL STAFF SECTION
FIELD PERSONNEL OPERATIONS SECTION
ANMC PERSONNEL SECTION
ADMIN. SECTION
TRAINING SECTION
AREA HQS PERSONNEL OPERATIONS SECTION
ANCHORAGE SERVICE UNIT
BARROW SERVICE UNIT
BETHEL SERVICE UNIT
Corporation
KANAKANAK SERVICE UNIT
KOTZEBUE SERVICE UNIT
Corporation
MT. EDGECUMBE SERVICE UNIT
Corporation
ALASKA INTERIOR SERVICE UNIT

RECOMMEND APPROVAL/DIRECTOR, AANHS ERC APPROVED/DIRECTOR, IHS


Purchasing + Contracting Section
-Kelly Simeonoff (Area Procurem. Officer)
Contract Admin Unit
Robert Wagner
Construction Services
Richard Andrews
P.L. 638 Contracting Unit
Deborah Sengelbaerts
Contract Spec.
Myrtle [illegible]
Nina Mills "
John Green "
Ken Hanninen "
Olinga Fargen "
Mary Jo Reese "

UNITED STATES GOVERNMENT

memorandum

DATE: September 14, 1982

Refer to: A-D (A-PFB)

REPLY TO ATTN OF: Director
Alaska Area Native Health Service

SUBJECT: Alaska Area Circular 82-53 (Revised)

TO: Executive Officers
Area Branch & Section Chiefs
ANMC Administrative Heads
Service Unit Directors
Health Clinics
Dental Clinics

Attached is Alaska Area Circular 82-53, to which minor revisions have been made since the effective date of July 16, 1982. Changes have been made to page 5, paragraph 5.A., to more clearly define the role of Area Program Officers. In addition, changes have been made to the table showing staff roles by deleting the words "as necessary," or "upon request" from the responsibilities listed under Program Officer.

The attached circular supersedes Alaska Area Circular 82-53, dated July 16, 1982.

G.H. Ivey
G. H. Ivey

Attachment (1)

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
Alaska Area Native Health Service
P. O. Box 7-741
Anchorage, Alaska 99510

Refer to: A-D (PFB)

ALASKA AREA CIRCULAR NO. 82-53

ASSIGNMENT OF ALASKA AREA PERSONNEL TO PERFORM 638 CONTRACT RENEWAL PROCESSING TASKS

Sec:
1. Purpose
2. Authorities
3. Definitions
4. Background
5. Discussion
6. Authorities and Responsibilities
7. Supersession

1. PURPOSE: The intent of this Circular is to identify specific personnel in the Alaska Area to be responsible for processing 638 contract renewals in accordance with the schedules and practices outlined in an Annual Procurement Plan and within the following authorities.

2. AUTHORITIES:

   A. The Indian Self-Determination Act (P.L. 93-638, Section 103, 25 U.S. 450g).

   B. CFR 42, Part 36, Subpart I, 36.207 Tribal Clearances Renewal Contracts.

   C. Indian Self-Determination Memorandum No. 82-3, Negotiation of P.L. 93-638 contracts for Fiscal Year 1983.

   D. The Code of Federal Regulations (CFR) Title 41 Public Contracts and Property Management, Chapter 3, Subpart 3-3.50 Procurement Planning.

3. DEFINITIONS:

   A. Procurement Plan: An administrative tool designed to enable the Project Manager, Contracting Officer and other AANHS staff involved in the contract renewal process to plan effectively for accomplishing procurement for the next fiscal year.

   The plan is issued on an annual basis by the Project Manager with the concurrence of the Contracting Officer.

B. Contracting Officer: The official delegated with contracting authority and procedural responsibility relevant to procurement law, regulation and policy. The Contracting Officer assures the best interests of the government are served by: 1) Pre-contract audit reviews, 2) Verification with the Project Manager that financial data is correctly depicted in the contract budget, 3) contract negotiations and contract closeouts.

C. Project Manager: The official delegated by Area Director memorandum to hold fiscal and program accountability for all the health care services provided by a tribal organization under a specific contract with the AANHS.

D. Project Officer: The official responsible for performing the day-to-day functions of procurement plan coordination and post award contract monitoring under the direction of the Project Manager. Depending upon level of responsibility, the responsibilities and authorities outlined in the attached table under Project Manager, may be delegated to individual Project Officers; however, the ultimate authority and responsibility rests with the Project Manager.

E. Finance Officer: The official delegated the authority to develop, administer and account for the AANHS budget. The Finance Officer performs the following major activities: compiles the annual AANHS budget, issues annual operating budgets (budget authorities), monitors fund control operations, briefs the Executive Staff on the financial status, maintains all required obligations of Native Health Corporations.

F. Program Officer: The official with expertise and training in a particular program area who is responsible for evaluation and review of those program aspects in a contract scope of work, and who reports and recommends on them to the Project Manager.

G. New 638 Contract: A contract between IHS and a tribal organization for management and operation of health services which have not previously been under contract.

H. 638 Renewal Contract: A contractual agreement between IHS and a Tribe which authorizes the Tribe to undertake the same scope of work as currently being provided under contract with minor or no revisions.

4. BACKGROUND: Implementing regulations to P.L. 93-638 Indian Self-Determination Act, contained in CFR 42, Part 36, state that the Director of Indian Health Service (IHS) delegates authority to IHS Area Offices to review and approve proposals for contracts under the Act. Implied in this delegation is continuing responsibility for conducting the entire contracting process, from preapplication to close out, in the most timely and efficient manner possible within the context of the law and regulations.

638 Contract regulations establish specific time frames, evaluation criteria, requirements and procedures under which AANHS must approve or disapprove contract proposals.

In addition, IHS recently issued policy guidelines in the form of ISDM's 81-1, 2, 3, and 4, and 82-1, 2, and 3 to simplify Indian Self-Determination contracting procedures, better utilize professional disciplines to plan for increased Self-Determination activities and to clearly define procedures and staff responsibilities throughout the process of contracting for new programs/program assumptions. The guidelines contained in these ISDM's are strictly adhered to in the Alaska Area.

Prior to issuance of the ISDM's, Alaska Area Circular 80-1, dated February 8, 1980, assigned specific contracting responsibilities and authorities to various AANHS personnel in regard to "renewal" and "new" contracts. With issuance of the new ISDM's, some of the functional roles depicted in Circular 80-1 are outdated. Alaska Area adherence to the ISDM's 81-1, 2, 3, and 4 effectively supercedes guidelines contained in Circular 80-1 with regard to new 638 contracts.

This Circular establishes improved procedures for planning and conducting procurement of 638 renewal contracts. The new guidelines provide a restructured format for the Annual Procurement Plan, and reassignment of AANHS personnel responsibilities for contract renewal actions.

5. DISCUSSION: The major contract renewal procedural changes established by this circular are summarized below.

   A. Assignment of tribal contract program responsibility and accountablity to Project Managers: Certification of funds for renewal contracts has previously been the responsibility of Project Officers under written authorization from Area Program Officers. Review of renewal program descriptions and objectives (scope of work) has been the responsibility of Area Program Officers.

   This circular reassigns program funds certification responsibility for tribal contracts from Program Officers to the Project Managers. Under the new system, A-BUDS will receive areawide obligation plans from Program Officers and, based on these plans, confirm the allocation of individual program funds directly to the Project Manager. The Project Manager will then certify the total amount of direct and indirect funds available to contract with the tribal organization. Project Managers will be responsible for coordinating the review process, and for seeing that review of renewal scopes of work by Program Officers is assured.

   B. Deletion of IPA (Detail)Salary Costs from the Certification of Available Funds: Before completing direct certification, the Project Manager will identify the amount of salary costs associated with employees who elect to IPA (Detail) under a 638 tribal contract.

These costs will be withheld from the total funds available to contract, until such time as the positions are converted from IPA to direct hire by the contractor. IPA salary costs will be paid directly from the Service Unit budget.

C. Annual Procurement Plan: The Project Manager will be responsible for preparation and issuance of an annual procurement plan which, in conjunction with the Contract Officer, identifies and schedules tasks, and designates personnel responsible for undertaking procurement activities leading to renewal of each 638 contract in accordance with 41 CFR 3-3.50 requirements.

The plan will document the pre-award, award, and post-award action steps required to process each individual tribal contractor's proposal. Prior to issuance, the renewal procurement plan will be reviewed by the Area Contracting Officer, a deadline for receipt of complete proposals by the contracting office will be set, and an HSA review date and contract negotiation date established.

Project Manager responsibilities are:

(1) providing, or arranging for assistance to tribal contractors in preparing contract renewal proposals;

(2) certifying all program funds available;

(3) conducting or arranging for program scope of work and budget review of proposals;

(4) contacting and using the resources of the 638 Team to deal with special problems which may arise between the Tribal Contractor and the Service Unit, or the Area Office.

(5) encouraging the tribal organization to submit a complete renewal proposal to Area office by the date specified in the Annual Procurement Plan.

6. AUTHORITIES AND RESPONSIBILITIES: Assignment of a Project Manager for each contract will be accomplished by memorandum from the Area Director. While responsibility for managing tribal contracts will be undertaken primarily in the Area Office, Service Unit Directors who desire to manage 638 Programs in their regions, and who have access to adequate support staff, and coordinating capability may request designation as Project Manager from the Area Director.

The attached table depicts Alaska Area staff personnel responsible for completing tasks in the 638 renewal procurement process. Outlined beneath each official are the specific authorities and responsibilities to be undertaken.

7. SUPERSESSION: Alaska Area Circular No. 82-53, dated July 16, 1982.

G. H. Ivey
Director
Alaska Area Native Health Service

May 31, 1983

Kokhanok Village Council
Kokhanok Bay
Iliamna, Alaska 99606

United States Senate
Select Committee on Indian Affairs
Honorable Frank Murkowski - Member

Dear Senator Murkowski:

Just received a letter from Senator Mark Andrews on an upcoming field hearing June 3, 1983, issues related to the reauthorization of the Indian Health Care Improvement Act.

Thank you for your concern.

Functions and value of the Community Health Aides are about priceless. Since doctors don't travel as much as before to rural villages, the role of the Health Aide has increased. Health Aides and Alternate Aides need more training. They are underpaid, in our case no retirement plan, and most have worked over 15 years. There are needs for preventive programs. Some villages still operate or run clinics from private homes.

The impact of budget cuts to IHS funding for services, personnel, training and priorities of treatment is unbelievable. The villages in rural areas are growing yearly. The health care services and programs are getting budgeted lower each year.

Competitive bidding on health care in Alaska should be as said, not come and leave the village in a hurry.

Water and solid waste sanitation facilities should be serviced or looked into very seriously. Water is a serious concern to villages.

Again, thank you for your time and effort.

Steve Nowatak
President, Village Council
Kokhanok Bay, Alaska 99606

POSITION PAPER OF ORUTSARARMUIT NATIVE COUNCIL ON ALASKAN AND HEALTH CARE IN ALASKA

MY NAME IS JOHN ANGAIAK, AND I WORK AS GENERAL MANAGER FOR ORUTSARARMUIT NATIVE COUNCIL, A BETHEL BASED TRIBAL COUNCIL. I AM PRESENTING THIS PAPER UPON THE REQUEST OF MR. EDWARD HOFFMAN, SR., CHAIRMAN OF THE BOARD OF DIRECTORS OF ORUTSARARMUIT NATIVE COUNCIL.

STATEMENT 1.

FUNDING AND FEDERAL BUDGET PROCESS WHICH IS PLANNED AT LEAST TWO YEARS IN ADVANCE FOR HEALTH CARE IN ALASKA, IN GENERAL, IS NOT SUITABLE FOR THE BUSH HEALTH CORPORATIONS, AS BY THE TIME THE ADVANCE PLANS BECOME ACTUAL, FEDERAL REGULATIONS CHANGE, CAUSING UNNECESSARY AND LAST MINUTE EXTENSIVE MODIFICATIONS WHICH ARE COSTLY IN TERMS OF MAN-HOURS, AND NO ALLOWANCE FOR INFLATION THEREAFTER.

RECOMMENDATION:

ALLOCATE FUNDS REGION BY REGION WITH A CERTAIN FORMULA THAT INCLUDES INFLATION ALLOWANCE ACCEPTABLE TO ALL EXISTING HEALTH CORPORATIONS IN ALASKA AS THEY HAVE MATURED IN THE LAST TEN YEARS OF OPERATION. ALASKA IS IN A UNIQUE SITUATION, AND MANY OF THE FEDERAL REGULATIONS IN HEALTH ARE NOT DESIGNED FOR ALASKA. ALL BUSH HEALTH CORPORATIONS KNOW THEIR SPECIFIC NEEDS, WHEREBY THEY HAVE AN ABILITY TO EFFECTIVELY CONTROL THEIR OWN DIRECT AND INDIRECT CHARGES ON THEIR HEALTH PRIORITY NEEDS.

IN GENERAL, BECUASE OF INFLATION, TWO YEAR ADVANCE PLANNING BECOMES AN UNDERFUND BY THE TIME IT BECOMES ACTUAL, CAUSING TERMINATIONS OF MANY ESSENTIAL HEALTH PRIORITIES IN ANY GIVEN REGION, PARTICULARLY IN THE YUKON-KUSKOKWIM HEALTH CORPORATION AREA WHERE IT HAS THE LOWEST EMPLOYMENT RATE, WORST HEALTH PROBLEMS, LARGEST NUMBER OF VILLAGES, LARGEST NUMBER OF NATIVES, HIGH COST OF LIVING, AND LOWEST PER CAPITA HEALTH EXPENTITURES OF THE SEVEN ALASKA SERVICE UNITES. BECAUSE OF THE INFLATION, INDIRECT CHARGES DEEPLY CUT INTO DIRECT CHARGES. DIRECT CHARGES ARE INTENTED TO MEET ALL THE ESSENTIAL HEALTH PRIORITIES IN ALL OF THE REGIONS.

STATEMENT 2.

IT APPEARS THAT THE HEALTH CORPORATIONS CANNOT ENTIRELY DEPEND ON STATE OF ALASKA FOR FUNDING AT THE CURRENT RATE OF ALASKA'S TREASURY. EVEN IF THE FEDERAL GOVERNMENT FUNNELS FEDERAL FUNDS FOR HEALTH CARE INTO ALASKA'S TREASURY, THE STATE GOVERNMENT WILL DEMAND ADDITIONAL OVERHEAD PERCENTAGE OFF THE DIRECT FUNDS FOR MANAGING FEDERAL HEALTH FUNDS, IN ADDITION TO THE INDIRECT RATES OF CENTRAL SERVICE UNIT, AND REGIONAL HEALTH CORPORATIONS. IT IS MOST LIKELY THAT ADDITIONAL INDIRECT COST TO THE STATE WILL CUT DEEPER INTO ALREADY BATTERED DIRECT HEALTH RATE. MEANWHILE, UNNECESSARY AMOUNT OF PAPERWORK WILL BE EXPECTED TO DOUBLE, AND AN UNNECESSARY MAN-HOURS EXPENTITURE.

RECOMMENDATION 1:

ALLOCATE FUNDS REGION BY REGION BASED ON THE ACCEPTABLE FORMULA, AND DEVISE A SYSTEM TO REDUCE HIGH INDIRECT RATE CHARGES TO ALLOW FOR AN INCREASE IN DIRECT CHARGES. FUNNELING OF FEDERAL HEALTH FUNDS INTO THE STATE TREASURY DO NOT NECESSARILY MEAN HEALTH DELIVERY SYSTEMS WILL IMPROVE.

RECOMMENDATION 2:

FEDERAL MATCHING FORMULA SHOULD BE CAREFULLY ASSESSED. IT IS POSSIBLE THAT THE STATE GOVERNMENT COULD MEET INDIRECT CHARGES, WHILE THE FEDERAL GOVERNMENT COULD MEET DIRECT CHARGES.

STATEMENT 3.

THERE ARE BASICALLY THREE DECISION-MAKING HEALTH BOARDS, BESIDES THE REGIONAL - THE INDIAN HEALTH SERVICE, ALASKA FEDERATION OF NATIVES, AND ALASKA NATIVE HEALTH BOARD. ALL ARE GENERALLY TEN YEARS OLD, MOST OF WHICH WERE CREATED SHORTLY AFTER THE CREATION OF ALASKA FEDERATION OF NATIVES. THEIR EFFECTIVENESS TO DATE AFTER TEN YEARS HAVE NOT BEEN EVALUATED, AND ARE SEPARATE BUT EQUAL DECISION MAKERS WITH OR WITHOUT THE REGIONAL BOARDS. TEN YEARS AFTER, THE REGIONAL HEALTH CORPORATIONS HAVE MATURED, AND NOW CAN STAND ON THEIR OWN TO SERVICE DIRECTLY TO THEIR CONSTITUENCY. ALL ARE LOGICALLY WITHIN THEIR OWN IMPACT AREAS.

RECOMMENDATION:

GIVEN THE MATURITY OF THE REGIONAL HEALTH BOARDS, THE ENTIRE EXISTING BODY OF HEALTH BOARDS IN THE STATE OF ALASKA NEEDS TO BE COMPLETELY ASSESSED MARKING TEN YEARS OF OPERATION TO SEEK WAYS TO IMPROVE COMMUNICATIONS AND ACCOUNTABILITY BETWEEN THEM FOR BETTER DICISION-MAKING IN VIEW OF FEDERAL BUDGET REDUCTIONS. STATEWIDE HEALTH BOARD WAS ESSENTIAL FOR ORGANIZING REGIONAL HEALTH CORPORATIONS TEN YEARS AGO. IT IS ESSENTIAL THAT THE RECOMMENDATIONS OF THE REGIONAL BOARDS MUST BE HONORED FOR ASSESSMENT.

THANK YOU VERY MUCH FOR YOUR ATTENTION.

CENTRAL COUNCIL
tlingit and haida indian tribes of alaska

EXECUTIVE COMMITTEE, 1982-1984

June 3, 1983

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The Honorable Mark Andrews
Chairman, Senate Select Committee
on Indian Affairs
Washington, D.C. 20510

Dear Senator Andrews:

Thank you for the opportunity to testify at the field hearings concerning reauthorization of the Indian Health Care Improvement Act, to be held June 3, 1983 in Anchorage. We have notified various members of our constituency with a known interest in the health professions.

Unfortunately I will not be able to attend the hearings. However, I have prepared testimony which I would appreciate having entered in the record on our behalf.

We appreciate your professional courtesy.

Sincerely,

John Hope
President

encls

CENTRAL COUNCIL
tlingit and haida indian tribes of alaska
EXECUTIVE COMMITTEE, 1982-1984

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Prepared Testimony
for
Senate Select Committee Hearings
Concerning
Reauthorization of PL 94-437
by
John Hope, President
Central Council
Tlingit and Haida Indian Tribes of Alaska
June 3, 1983

Mr. Chairman:

My name is John Hope, I'm President of the Central Council, Tlingit and Haida Indian Tribes of Alaska, a Federally-recognized tribe. We have a membership of over 15,000. I wish to make a general statement with respect to reauthorization of the Indian Health Care Improvement Act.

First of all I would like to state that we hold our relationship with the United States Government as very precious, a relationship that saw our people having a very decided advantage in the beginning. We could have exercised options that would have made the beginning of this Nation more difficult, but because we chose to accommodate, a great Nation was born.

Some of the agreements made with the tribes are in effect to this date - to our mutual benefit. I mention this so that we might address the subject in the proper perspective. There are some, especially in government, who are under the impression that health and education programs for Indians are welfare programs and evidence of need should be a criterion for eligibility. We, who have given up our lands, remember these benefits are part of a commitment between governments.

The Congress has addressed the health and education problems of our people from time to time and, together with input from the Native peoples of this land, have developed good legislation - all well intentioned. The Snyder Act; Public Law 93-638, the Indian Self-Determination and Education Assistance Act; the Indian Reorganization Act of June 18, 1934 amended May 1, 1936;

the Indian Child Welfare Act; and the Indian Financing Act of 1974; all have been directed to improving Indian welfare. However, by and large the programs have been underfunded and the goals not attained. Because of this the Native community is still dependent.

Mr. Chairman, you realize that even municipal and state governments with large land bases are not able to adequately meet their constituents' needs. You can appreciate the problems of our Native peoples, who are either landless or have lands that were not regarded as of much value. We are handicapped when it comes to providing our own services.

Since this oversight hearing addresses the need to reauthorize PL 94-437, I would like to stress that indeed the health needs of America's first citizens have not been adequately met and that by any standard we, as a people, are far below the national norms.

Mr. Chairman, we as Indians appreciate and understand the problems associated with balancing the national budget. We realize that in these times a critical review of our national priorities is necessary. However, we do not feel that as a people we are just an administrative line item. We are more than a budgetary line item -- we are the people to whom a nation made a commitment. For a people and a nation to remain great, the commitment must be honored.

In Alaska we are witnessing a continuous assault on our status as tribes and entitled to the same benefits as our southern brethren -- some of it caused by the perceived wealth of this state -- some of it instigated by a desire on the part of the Administration to find a beginning for termination. A start to termination that will have the least resistance. The erosion has begun.

We believe the Congress should remember the special relationship this country has with its indigenous peoples and set an example for other nations to witness and benefit from.

In closing I would like to quote from Felix Cohen, the great American whose Handbook on Federal Indian Law is a bible on Indian law. Mr. Cohen states,

> ". . .Like a miner's canary, the Indian marks the shifts from fresh air to poison gas in our political atmosphere; and our treatment of Indians, even more than our treatment of other minorities, reflects the rise and fall of our democratic faith."

NATIVE VILLAGE OF TYONEK, ALASKA

TYONEK

Village Office
TYONEK, ALASKA 99682
TELEPHONE 583-2201

Management Office
1675 C STREET - ROOM 246
ANCHORAGE, ALASKA 99501
TELEPHONE 279-6214

June 2,1983

Mark Andrews Chairman
Select Committee on Indian Affairs
Washington D.C. 20510

Dear Mr. Andrews:

The impact of the budget cuts for I.H.S. was felt almost immediately in our village. It's been almost a year since a dentist came here and people keep asking when the dentist is going to come. Next August it will be a year since the I.H.S. doctor has been down here,Even though their are regularly scheduled flights to Anchorage some person's still can't afford to go in to see the dentist or doctor.

People have been changing their medical and dental appointments over and over again because they don't have the money to go in. The cut backs in ALL areas have affected the poor more than any other in our village.

The community health aide has been benefical to our Village, and I certainly hope more funding for training, equipment and supplies, and salary will be added not taken away.

Every time the health aide goes in for training she should get a raise in pay for being that much more skilled and taking on that much more responsibility.

The community health Representative program has been benefical to our village in the Emergency medical services area. This program needs to be expanded not cut back. We need more funds to buy equipment, supplies and train more people as E.M.T.'s and to further train the present E.M.T.'s We have in our village.

At the present time we don't have a community health Representive in the area of health prevention because of the lack of funds and we need one.

Sincerely,

Al Goozmer, President

Myra Starkloff C.H.R.-E.M.S.

AG/DJB

• CARDIOVASCULAR AND THORACIC SURGERY

SUITE 2
3300 PROVIDENCE AVE.
ANCHORAGE, AK 99504

ARNDT von HIPPEL, M.D.

OFFICE 561-1174
RESIDENCE 279-3740

May 7, 1983

The Honorable Frank Murkowski
United States Senator
701 C Street
Anchorage, Alaska 99501

Dear Senator Murkowski:

I have been in contact with Senator Stevens on the subject of Native health care in Alaska, and I understand that you will soon be holding hearings on this subject in Anchorage.

I therefore enclose copies of our correspondence for your information.

Please contact me if I can be of any assistance.

Sincerely yours,

Arndt von Hippel, M. D.

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
Alaska Native Medical Center
Box 7-741
Anchorage, Alaska 99510

March 17, 1982

Refer to: ANC-MED

Division of Public Assistance
Medical Review Section
1569 South Bragaw St. Suite 205
Anchorage, Alaska 99504

Attention: Karen Mortz

Dear Ms. Mortz:

Thank you for taking the time for our recent meeting to discuss the rationale we utilize in deciding to send our cardiac surgical cases to San Francisco. I hope the meeting was as useful to you and your staff as it was to us. Below I will document our reasoning as we reviewed it with you. A variety of variables are considered when we refer an Indian Health Service patient for cardiac evaluation or treatment. Our position is based on a combination of clinical and financial factors. These factors are:

I. PERSONNEL:

Robert Sullivan, M. D. is a senior cardiologist, board certified, and was formerly Chief of Cardiology at the PHS Hospital in San Francisco. In that position he had, for the past 10 years, provided us with cardiac consultation through field clinics in the bush and bi-annual ANMC cardiology clinics. He arranged for, and performed, cardiac diagnostic catheterizations in San Francisco and made appropriate cardiac surgical referral in San Francisco when necessary. With the closure of the San Francisco PHS Hospital, Dr. Sullivan has joined the ANMC Department of Medicine and has been assigned to San Francisco to continue to provide the same services. These now include bi-annual cardiac field clinics in Barrow, Kotzebue, Bethel, Kodiak, Dillingham and Southeast Alaska (as well as, of course, ANMC in Anchorage). Dr. Sullivan knows many of our cardiac patients as a consequence of his 10 years Alaskan experience and he therefore becomes an ideal person to continue the clinic coverage. He receives no other financial recompense for these services other than his salaried position with us.

II. CONTINUITY OF CARE:

Cardiac-Surgical procedures in our patients usually occur after a period of evaluation, usually in cardiac clinics. Most often, Dr. Sullivan is already familiar with a patient from such clinic visits when the time comes for surgery. The patient, in turn, knows him and has received a briefing about treatment alternatives, risks of surgery, and the like. Again, after surgery, the patient will usually receive follow-up care from Dr. Sullivan who, having been involved in the diagnostic and surgical deliberations, is intimately familiar with the patient and problems peculiar to the patient's medical situation. Communication between health providers is enhanced since Dr. Sullivan is part of the Indian Health Service system and knows most of our field physicians. Continuity of care is most critical in chronic disease states; many of our cardiac patients present in this way, and, we believe, are best cared for by a small number of providers who have been, and will be, caring for the patient through time.

III. SAN FRANCISCO:

The choice of San Francisco as a referral location is, of course, determined by Dr. Sullivan's location there. He has diligently researched the surgical options in that area and arranged our affiliation with several high quality surgical teams experienced in cardiac valvular and vascular surgery. We have no such liaison with cardiologists in Seattle or Portland and have no prospects at developing them. Dr. Sullivan is not familiar in detail with surgical options in Seattle or Portland so that he could not provide such service. Part of the decision for using San Francisco rests entirely on a financial basis as the programs we use in San Francisco have provided Indian Health Service a distinct financial advantage.

IV. FINANCIAL:

We have negotiated a series of contracts with three (3) hospitals in the Bay Area (Mary's Help, Letterman Army Medical Center and Palo Alto Veterans Hospital: all of which have large cardiac programs). In each case we can purchase the services our patients require at very substantial savings. Upon comparing costs at a number of geographic locations, including Anchorage, we concluded that we can purchase the required services at costs of up to 60% less than all of the other locations we investigated. Additionally, as indicated above, the quality of services under our contractual arrangements are very good.

I trust that this letter is sufficiently detailed to justify our rationale as to the ANMC decision to send Alaskan patients out of the state for this type of care.

Sincerely yours,

Richard E. Zitzow
Executive Officer

• CARDIOVASCULAR AND THORACIC SURGERY •

ARNDT von HIPPEL, M.D.

SUITE 2
3200 PROVIDENCE AVE.
ANCHORAGE, AK 99504

OFFICE 276-2882
RESIDENCE 279-3740

April 16, 1982

Division of Public Assistance
Medical Assistance
1569 South Bragaw, Suite 205
Anchorage, Ak. 99504

Dear Sirs:

Medicaid should no longer support routine heart catheterization or routine heart surgery procedures performed outside of Alaska, for the following reasons.

The heart catheterization laboratory at Providence Hospital now has a ten year track record of superb diagnostic accuracy and safety. Their equipment, staffing and technical results are excellent. In other words, the six or seven Board Certified cardiologists at Providence Hospital have proven that they can skillfully diagnose and institute appropriate treatment for patients with disease of the heart or great vessels. It should be emphasized that each of these Board Certified cardiologists is an expert in, and commonly evaluates, rheumatic heart disease, rheumatic and non-rheumatic heart valve disease, coronary artery disease, hypertension, heart rhythm disorders, and other congenital and acquired disorders of the heart and great vessels. One of them, a Board Certified pediatric cardiologist, is a specialist in evaluating and treating similar conditions in infants and children.

The rheumatic heart disease that is more common among the native population is often seen in the non-native population as well, and is a basic, common, and well understood part of the training and practice of each of these Board Certified cardiologists. They have clearly demonstrated that they can diagnose and treat (or recommend treatment for) all such conditions with greater efficiency, greater convenience, greater safety, greater diagnostic skill and at comparable cost. Therefore medicaid support for routine cardiac catheterization performed outside Alaska is unnecessary, discriminatory, detrimental to adequate care and follow-up, and unnecessarily costly to both the state and to the individual patient who is usually involved without properly informed consent in such inefficient long distance diagnostic or therapeutic endeavors.

In support the the above contentions, consider the following:

Many cardiac evaluations performed here do not lead to heart catheterization. Obviously, it is not cost effective to arrange transfer of a patient to a cardiologist in California for an evaluation that can be done here by an equally well trained and qualified cardiologist when such an evaluation may even show cardiac catheterization is not needed. Similarly it is not cost effective to have a California specialist see a patient who may require several or regular visits to a cardiologist for evaluation of the progress of his disease and/or his ongoing response to a long course of treatment, as is often the case. Since regular trips to California are obviously out of the question, there must be great pressure on the cardiologist in California to do a catheterization on this initial trip even if this might well not be in the patient's best interest, in order to send some "results" back with the patient. Similarly there would be great pressure on the referring physician (in the various native hospitals around the state, for example) to refer only clear cut advanced cases for evaluation, since it would obviously appear foolish to send a sick patient 3000 miles at great cost for an opinion that would be better obtained locally. The tendency, as I see it, is thus to either let many persons needing evaluation deteriorate here, without such expert evaluation, although such is readily available locally, or to push unnecessary catheterization procedures to avoid giving the appearance of having made a great expedition "for nothing", i.e. no catheterization was needed or performed. Letting patients deteriorate without specialist evaluation and treatment, and unnecessary catheterization, are both injurious to the health of individual Alaskans and to the purse of the medicaid program subjected to such demands (and often required for later costly support of an unnecessarily deteriorated chronic invalid, who might earlier have been returned to good health).

Finally, why send them out, even for definitely needed heart catheterization, when it is better done here, closer to the patient's relatives and other support systems, probably less expensive in dollars and clearly safer for the patient and better medical practice.

The American College of Surgeons has had a policy against itinerant surgery for many years. A specialist physician who merely travels to an area to perform a procedure and has little role in the preoperative selection and evaluation before he arrives or the postoperative care of the patient after he completes the procedure and leaves that area is considered unethical. How does this differ from the current medical policy of sending an unsophisticated patient (who is not aware that equal or better care is available locally) far away for a test or procedure. Once again, such a patient is selected by non-specialists, not evaluated and treated over an adequate period of time by a specialist and soon returned to a non-cardiologist for follow-up care - is this not unethical (as well as excessively costly)?

Why does the ANS choose a cardiologist in California when more recently trained, highly skilled and experienced cardiologists, here within the state, are ready and willing to cooperate with the native hospitals, to run cardiac clinics regularly, even at no cost to the government? Could there be a conflict of interest in these referrals outside? I wish you would investigate. In the meanwhile why not use the best, most accessible and least expensive cardiologists - our own men and women of proven competence who are ready willing and able to serve the poor as well as the rich.

These same arguments pertain with equal force to routine cardiac surgery performed outside with medicaid support. We now have an eight year record of cardiac surgery which is equally or more successful than that provided anywhere else. We are, of course, not dealing with thousands of "cases" but rather with dozens and hundreds of Alaskans who have undergone heart surgery at Providence Hospital since 1974. Initially our patient load was small, last year it was about 140, for 1982 we anticipate perhaps 200 cardiac surgery operations (over 50 so far this year). Our total cardiac surgery experience in Alaska is now approximately 575 patients. The hospital mortality rate from elective or urgent coronary bypass is about 1%. The hospital mortality rate for elective or urgent valve surgery so far is 0%. We have done more than 20 valve procedures, mostly replacements, many for rheumatic valve disease. These valve procedures (including three double valve replacements and one triple valve procedure) were often combined with coronary bypass as indicated. With no surgical mortality and a very acceptable complication rate we are pleased that all survived their heart valve operation and left the hospital improved. These valve procedures were often performed on extremely ill patients (initially mostly those too sick to be moved, until we demonstrated our competence on these patients to the cardiologists). We still refer patients outside for procedures in which we have no experience when this is possible and in the patient's best interest. For example, in 1981, two patients with a rare condition (sinus of valsalva fistula) were referred outside because I had never participated in surgery for this condition. Incidentally, the heart surgery performed at Providence Hospital is recognized by many heart surgeons around the country for its excellence. Our 1% surgical mortality for elective or urgent coronary bypass and 0% mortality rate for elective or urgent cardiac valve replacement is something to be proud of. It shows that we are capable of equal or better care for these conditions at Providence Hospital than the outside centers to which such routine coronary bypass or routine rheumatic or other valvular conditions might be referred. I would be happy to compare our surgical results with those of any other center in the country.

Why then does medicaid send poor patients (often referred by PHS doctors who have never even allowed us to present our results to them) Outside, when better surgical care with comprehensive preoperative evaluation, highly successful surgery, and prolonged postoperative cooperative care by surgeon and cardiologist is readily available locally? I have never delayed or altered the care of any patient based upon his or her ability to pay. I am almost always readily available (seven days a week) for an opinion on the feasibility of surgery at no cost. I am almost always available for evaluation of early or late post operative complications (fortunately few) at no cost to the patient or his insurance carrier or medicaid. We anticipate even more cardiac surgeon coverage now, as one or more other cardiac surgeons have declared their intent to enter private practice in Anchorage.

Clearly the patient referred outside for care - especially the U.S.P.H.S. referrals to California, have not given informed consent for such care, being unaware of alternatives available (or that ethically should be made available) to them by the referring U.S.P.H.S. physicians, who thus unnecessarily make them subject to such "itinerant-equivalent" surgery. Surgery after 3000 miles (unnecessary) travel is not likely to be delayed or substituted for by a trial of medical therapy under close long term medical supervision, nor are the medical or surgical results likely to be reevaluated regularly by an appropriate local specialist (cardiologist or cardiac surgeon) as would be possible here.

SUMMARY It is unnecessary, unwise, discriminatory, costly, unsafe, and harmful for medicaid to support routine cardiac catheterization and routine cardiac surgical procedures Outside. These can far better be performed at equal or lower cost within the state by fully trained and experienced cardiologists and surgeon(s). Support of the local facility would also reduce the cost of equipment that must be spread over the patients available. Providence Hospital specialists are fully qualified and experienced in all heart diseases likely to affect our native population, specifically including rheumatic heart and valve disease. Your early correction of this ongoing medical injustice to Alaska's poorer and less sophisticated heart patients is urgently requested.

Sincerely yours,

Arndt von Hippel, M. D.

AvH/alc

APR 30 1982

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAL REVIEW SECTION

1569 SO. BRAGAW, SUITE 205
ANCHORAGE, ALASKA 99504
(907) 338-5590

April 27, 1982

Arndt von Hippel, M.D.
3300 Providence Drive
Anchorage, AK. 99504

Dear Dr. von Hippel:

Thank you for your thoughtful and informative latter of April 16, 1982, regarding routine cardiac care within the state of Alaska.

As you are aware, the State of Alaska Medical Review Section is currently evaluating their policy of transporting Alaska patients out of state for these services. Your letter certainly provides information helpful in making an ethical and prudent decision.

This office will keep you informed on the progress of this policy evaluation. Again, thank you for your assistance in this matter.

Sincerely,

Judy

Judith Moe

JM/rc

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE

Alaska Native Medical Center
Box 7-741
Anchorage, Alaska 99510

May 12, 1982

Reply to: ANC-DIR (ANC-SOS)

Karen Martz
Office Supervisor
Medical Assistance
1569 South Bragaw, Suite 205
Anchorage, Alaska 99504

Dear Karen:

It is my understanding from talking with Alaska Native Medical Center staff that your office is now requiring ANMC medical staff to secure a "second opinion" on all cardiac cases which we plan to send for surgery and/or treatment to San Francisco and for which we seek pre-authorization under Medicaid.

I request that you write me a letter explaining your justification for this new requirement - of restricting patients from cardiac treatment without a second opinion by a cardiologist - when in fact this action is not required of any other pre-authorized treatment or other programs.

I will appreciate a prompt reply.

Sincerely,

Osamu H. Matsutani, M.D.
Director

cc:
Helen Bierne, Commissioner
Dept. of Health and Human Services

Dean Tirador, Deputy
Dept. of Health and Human Services

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
MEDICAL REVIEW SECTION

JAY S. HAMMOND, GOVERNOR

[illegible] SO. BRAGAW, SUITE 206
ANCHORAGE, ALASKA 99504
(907) 338-5590

May 20, 1982

Osamu H. Matsutani, M.D., Director
Alaska Native Medical Center
Box 7-741
Anchorage, Alaska 99510

Dear Dr. Matsutani:

I am writing at your request regarding our policy of authorizing cardiac treatment in San Francisco for patients with dual IHS/Medicaid benefits only after a second opinion has been obtained from a local cardiologist.

You have asked for justification of this requirement and you state that the Medicaid program is restricting patients from cardiac treatment and further state that obtaining a second opinion is not required of any pre-authorized treatment or other programs.

This office has for years routinely requested second opinions before authorizing out-of-state (and some in-state) treatment for our Medicaid and GRM clients. Our regulations mandate that we not authorize treatment outside the state if it is available in Alaska, and also that we not authorize travel beyond the closest available source for adequate care. Thus, second opinions have been used to verify the need to send clients out-of-state, and let me assure you it has been a frequent and common request during the four years I've worked in this program.

Since we now no longer have a physician on our staff, it has become increasingly important for us to rely on consultations and second opinions, and we have found that physicians have been willing to assist us in determining that Alaskan resources have been exhausted before sending patients Outside. I personally feel this has been important in terms of providing good patient care, of supporting Alaskan medical services, and prudent use of public funds.

In the March meeting between my staff and yours (Dr. Neilson, Dr. Barrett, Mr. Zitzow and Mr. Hermansen), the ANMC representatives persuaded us that San Francisco was the only place where Alaska natives could receive adequate cardiac care, and said that IHS would pay all travel costs if Medicaid would pay hospital charges. I agreed to this proposal because the arguments they presented for special needs of this group were most convincing and sounded reasonable.

Then the furor began. Both this office and our Central Office in Juneau have received phone calls and letters from our local medical community protesting this arrangement. Objections have been made about transporting patients long distances for treatment which may be available locally, and questions have been raised as to whether sending native patients to San Francisco is unnecessary, unethical, discriminatory, and detrimental to adequate care and follow-up. I quickly realized I'd heard only one side of the story and had made the agreement prematurely without adequate research. So I informed Mr. Zitzow that a second opinion from a cardiologist must accompany all requests for cardiac care to be provided under Medicaid outside of Alaska.

To further clarify this issue, in the event that a consulting cardiologist agrees referral is necessary, from now on authorization will be given to send these patients to the closest point (Seattle), as would be the case with non-native Medicaid recipients.

I hope I have answered your questions.

Sincerely,

Karen Martz

Karen Martz

cc: Helen Beirne, Commissioner, DH&SS
Dean Tirador, Deputy Commissioner, DH&SS
Allen Korhonen, Deputy Commissioner, DH&SS
Rod Betit, Director, DPA
Robert Ogden, Assistant Director, DPA

KM/rc

• CARDIOVASCULAR AND THORACIC SURGERY •

ARNDT von HIPPEL, M.D.

SUITE [illegible]
[illegible] PROVIDENCE AVE.
ANCHORAGE, AK [illegible]

OFFICE [illegible]-2882
RESIDENCE [illegible]

October 4, 1982

The Honorable Ted Stevens
United States Senate
Washington, D. C. 20510

Dear Senator Stevens:

Why are Alaska Native Health Service beneficiaries referred to a former P.H.S. cardiologist in San Francisco when better care could easily be obtained in Alaska at lower cost? If Natives needing heart catheterization or heart surgery are not benefitted by this non-competitive "arrangement," who is? I enclose a letter from A.N.S. to Medicaid trying to justify this referral of sick Alaskans to California. I also enclose my letter to Medicaid as a sample of those sent in opposition. Although Medicaid no longer assists the A.N.S.in this costly make-work project for California physicians, the California monopoly continues. Can there be a conflict of interest in this arrangement?

Even a dedicated and competent San Franciscan can hardly provide equivalent to local care for sick Alaskan patients, especially those requiring urgent specialist treatment or close specialist follow-up. A Californian is also unlikely to even meet some of the native patients who might benefit from a timely visit to a cardiologist, due to cost and distance being balanced against a cardiac condition of unknown significance or severity. There must be many patients needing heart care for whom the inevitable delays involved in such transfer outside, far from family and friends, can be harmful. I am aware of deaths allegedly due to this California referral policy (one is currently under litigation).

Our many excellent Board Certified Anchorage Cardiologists are constantly available to provide local evaluation, treatment and follow-up for Alaska native or non-native heart patients. They already hold appropriate clinics at out-of-Anchorage locations and can easily increase such evaluation and follow-up activities when indicated. The fine hospital facilities and staff at Providence are complete and competent, and recognized as providing superb care to satisfied cardiac patients even from overseas. Our Board Certified or Board Eligible surgeons also have an enviable "track record." Why then have we not been approached or evaluated for a local care option. How could A.N.S. doctors conclude that the San Francisco expedient was either cheaper or better without an intensive review of local costs and results? Certainly they attend our conferences and live in the same town, so they must know we are both competitive in our charges and competent in our work. Could their present non-competitive "arrangement" with a Californian (of which I know very little) even be illegal, as well as bad medicine? Can an occasional visit by a California cardiologist be comparable to the care constantly available from our local specialists? I hope you will investigate this matter. I will rest happy if you can show me that the A.N.S.-California connection is both legal and in the best interests of Alaska Natives, but I fear this is not so.

Sincerely yours,

Arndt von Hippel, M. D.

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE

October 26, 1982

ALASKA AREA NATIVE HEALTH SERVICE
BOX 7-741
ANCHORAGE, ALASKA 99510

The Honorable Ted Stevens
United States Senate
Washington, D. C. 20510

Dear Senator Stevens:

I am writing to you in response to your letter of October 15, 1982. Your letter to me was prompted by a letter of concern to you from Arndt von Hippel, M.D. regarding the referral of Alaska Native patients to San Francisco, California, for cardiac care.

Referring to Dr. von Hippel's letter, I wish to clarify first that the referred to cardiologist in San Francisco is not a former PHS cardiologist, but rather is an active duty USPHS Commissioned Officer assigned permanently to the Indian Health Service and is an active medical staff member of the Alaska Native Medical Center. His name is Robert Sullivan, M. D. He is a highly skilled and experienced cardiologist and has been providing cardiology services to Alaska Native patients for many years. He is a career officer with nearly twenty years of active duty. Dr. Sullivan spends several months each year in Alaska. He travels to all of our field hospitals providing cardiology services as well as holding cardiology clinics here at the Alaska Native Medical Center. Dr. Sullivan is also on the staff of the Letterman Army Medical Center in San Francisco, Mary's Help Hospital in San Francisco, and the V.A. Hospital in Palo Alto, California.

Dr. von Hippel implies that deaths have resulted from patients being referred to San Francisco for care. We completely refute this implication. Surgical deaths have occurred in patients referred to the San Francisco surgery programs as occur in any cardiac surgical program. These deaths did not occur because of transfer to San Francisco. We are not aware of any cases under litigation which relate to referral of patients to San Francisco for care.

We do refer Alaska Native patients to San Francisco for care. Through this referral mechanism, we obtain a very high quality service at acceptable costs. This is not meant to imply that the Anchorage hospitals, Anchorage based private cardiologists, and Anchorage based private cardiovascular surgeons do not provide quality care. However, through a system developed with, and through Dr. Sullivan, dating back to 1971, we obtain high quality service at a reasonable cost and maintain continuity of care.

Maintaining Dr. Sullivan's residence in San Francisco allows him to selectively choose one of the three hospitals where he feels the patient will receive care best suited for his condition. Each of the three hospitals Dr. Sullivan utilizes have large and very active cardiovascular surgery programs. Two of the hospitals are federal hospitals which allows us to achieve significant economies in the total cost of purchasing cardiovascular surgical care for our patients. We have a contractual arrangement with the third hospital, Mary's Help, which also offers us a significant economic advantage. Additionally, with Dr. Sullivan being a full time commissioned officer member of our staff, we do not incur any additional cost to the government for the cardiologists services.

When we compared the average cost of obtaining cardiovascular services in Anchorage versus San Francisco for our patients, we found that our total costs are approximately 50% less under our current arrangement in San Francisco. When we can achieve economies of such magnitude for this expensive type of health care we can, of course, provide treatment and care for many additional patients eligible under our Contract Health Services Program. Additionally, our long standing relationship with Dr. Sullivan and the San Francisco Bay Area hospitals has documented very high quality service for our patients.

We do not totally preclude the possibility of obtaining cardiovascular services in Anchorage in the future. We do use local cardiologists for consultation when immediate consultation is necessary. As we have outlined above, we are currently obtaining a very high quality service at significantly below local costs. We feel we are safeguarding the public interest by obtaining these services in the most efficient and economic manner possible while also providing excellent health care for our patients.

I hope that the above adequately covers the rationale for our current method of management of Alaska Native cardiac patients. Please advise me if you have need for further information.

Sincerely,

G.H. Ivey

G. H. Ivey
Director
Alaska Area Native Health Service

cc: Director
Indian Health Service

• CARDIOVASCULAR AND THORACIC SURGERY •

SUITE 3
3300 PROVIDENCE AVE.
ANCHORAGE, AK 99504

ARNDT von HIPPEL, M.D.

OFFICE 276-2882
RESIDENCE 279-3740

December 15, 1982

The Honorable Ted Stevens
United States Senate
Washington, D. C. 20510

Dear Senator Stevens:

Thank you for providing a copy of the October 28 letter from the Director of the Alaska Native Health Service. As almost every statement he made was either incorrect or misleading, I will respond paragraph by paragrah.

(1) Dr. Sullivan apparently was appointed to Alaska Native Medical Center in Anchorage on closure of the P.H.S. Hospital in San Francisco. I understand that Alaska Native patients continue to be sent to San Francisco for his evaluation and onward referral mainly because his wife prefers to remain there. Regardless of how often Dr. Sullivan visits Alaska, a cardiologist in Anchorage is better than two in San Francisco if their patients live here. Dr. Sullivan will soon become eligible to retire (into private practice in a San Francisco Hospital that he has helped to keep full?) Please watch this situation for the next episode of Alaska Native Health programs being modified primarily for the convenience of USPHS bureaucrats (and their wives).

(2) Recent Alaska Native deaths related to this long distance care include:

(A) Nick A. Hank who died on 8/14/82 of a fatal myocardial infarct while awaiting referral to San Francisco for evaluation of angina.

(B) Andrewski Gloko (10/18/82) apparently died of inadequately evaluated and treated valvular heart disease. (Other names can be provided.)

(C) Currently under litigation: The case of Mark Alexander, who died of ruptured thoracic aorta in 1979 after about 16 hours hospitalization in ANMC, following a motor vehicle accident. In sworn testimony on this case Dr. Joseph Wilson stated that transfer of Mark Alexander to the lower 48 (possibly San Francisco) was one of his options (prior to this patient's sudden death) and preferable to local care because he personally disliked me for past criticisms of USPHS medical care (and other alleged reasons) although he didn't question my competence, and personally knew no surgeons "Outside" who could correct this patient's torn aorta (Deposition of 11/3/82).

Please note that I have not been investigating ANHS cardiology/cardiovascular surgery referral deaths and litigations - the above are merely recent examples that were brought to my attention by the deceased patient's relatives, friends or physicians. I have no doubt that these 3 patients represent only the visible tip of the iceberg of a far larger Alaska Native patient population damaged or prematurely dead as a result of the present USPHS policy of cardiology/cardiovascular surgery patient referrals to an old buddy whose wife prefers living in San Francisco.

(3) Please ask for documentation of the alleged reduced cost and high quality of care provided Alaska Natives through Dr. Sullivan in San Francisco. Clearly, continuity of care must suffer from such itinerant medical/surgical evaluations and follow-up, which is why, for example, the American College of Surgeons and other groups have repeatedly declared itinerant surgical care unethical. How can Dr. Sullivan possibly justify the evaluation and follow-up of Alaska cardiology/cardiovascular surgery patients by remote control from San Francisco when equal or better care is readily available in Alaska? He too, as an itinerant physician, is providing inferior care by the mere fact that others equally or better qualified in Anchorage are thus bypassed, and native patients who might be benefited are denied access to such local care.

I submit, Senator, that Gerald Ivey is attempting to pull the wool over your eyes when he says how fine it is that Dr. Sullivan is able to select from among three hospitals in San Francisco for that institution where "he feels the patient will receive care best suited for his condition". Any cardiovascular center of good quality is competent to evaluate and treat almost all cardiovascular conditions likely to be found in adult Alaska Native patients, and this clearly includes us in Anchorage. To say that each of these three San Francisco institutions can do less suggests that all three programs may be inadequate.

(4) Please ask for documentation that the ANS ever evaluated the average cost of obtaining cardiovascular services in Anchorage versus San Francisco for their patients. I strongly believe this to be an untrue statement (based either on hearsay or simply a plain lie). Neither I, nor, as far as I can learn, our cardiologists or Providence Hospital were (even queried or) asked to bid prior to this San Francisco/Sullivan connection being established upon closure of the USPHS hospital in San Francisco.

I suspect private care in Alaska for Alaska Natives can easily be less expensive, as well as safer and more effective, than similar care now available from San Francisco government hospitals or Mary's Help. Specifically, would you find out exactly what the contractual arrangement with the Mary's Help Hospital is, so we can stop talking vaguely and deal with concise arrangements and costs, which I suspect we can improve upon. I am sure that I personally will not be allowed an opportunity to provide care under such an arrangement, due to past disagreements about the quality of USPHS medical care. This is why I am doing all the complaining at this time, for my relationship with USPHS physicians has already soured. Incidently, I can provide the details of prior USPHS inadequacies of medical care and plain incompetence (leading to Native deaths and disabilities) upon which previous years complaints and criticisms were based. This should document that my past efforts to improve USPHS care were both medically and ethically indicated. I do not wish to criticize individual physician errors — I, too, make mistakes. I only want to correct a system of care that is so inadequate that it has frequent bad results. Why should an Alaska Native not have access to the first rate medical and surgical care available to your other constituents?

(5) The 50% figure is a simple lie to the best of my knowledge. Actually, as pointed out in my previous letter, far fewer Alaska Native patients get adequate care (due to exactly this costly, inefficient and immoral long distance connection). Incidently, we do provide excellent care to Alaska natives (with or without insurance) but only to those educated and knowledgeable about their own rights, and about our competence and facilities. In the past, some pacemaker work was done here for Alaska Natives by Dr. Hood, a personal friend of Dr. Wilson.

(6) Obviously they do not wish to preclude us from providing care - I have been asked to see two patients with possible ruptured thoracic aorta since the 1979 death (now under litigation, referred to above). The comment on costs is again an unresearched fabrication as far as I know, and almost surely untrue, especially if all cost factors are honestly included, and in any case should be documented. If Dr. Sullivan retires after putting in his 20 years, we may be needed again. The care referred to, is in my opinion not "excellent" but "often lousy and unethical" for reasons referred to in this and my previous letter.

(7) Not one fact, not one document - please get the details, if you can, of this San Francisco connection. If you find significant evidence that I am incorrect in the majority of the above I will gladly provide you and the USPHS Director a written apology. I suspect, however, that further investigation by your office will only document that we have a distasteful, unethical, ineffective and harmful arrangement for the care of Alaska Natives that is unnecessarily costly as well.

SUMMARY: In order to provide a fair evaluation of the current peculiar USPHS cardiovascular consulting and care arrangements with San Francisco hospitals we need the following information: (1) What non-competitive contractual arrangements were entered into by and for Dr. Sullivan (a USPHS cardiologist soon eligible to retire and join the private sector) with these San Francisco Hospitals (especially Mary's Help, a non-federal hospital)? What are the arrangements between Dr. Sullivan and the California surgeons who provide Alaska Natives with cardiovascular care in San Francisco, especially at Mary's Help? What are the qualifications of these surgeons? Do they have acceptable results? Are they still in training or are they fully qualified cardiac surgeons? Is there any possibility of conflict of interest in this apparently frivolous rather than medically indicated arrangement? Please compare the outcomes of surgical care in the three San Francisco hospitals with material we can easily provide on our own Anchorage cardiology and cardiovascular surgery success rate.

All this reference material and documentation surely must be readily available to the USPHS in Anchorage, for they have allegedly based their sweetheart relationship with San Francisco on this evidence, so let's see their evidence. Although I will happily provide our costs and results also, they supposedly already had this information (prior to setting up the San Francisco connection); so let them show us what material they gathered about local Alaska cardiac care at that time (which I suspect is none).

I am sorry to cause so much paperwork but I cannot stand back and watch this systematic abuse of Alaska Natives continue. As mentioned, it is unlikely to benefit me personally if we can return Alaska Natives to competent Alaskan cardiologists for care, as my relationship with the USPHS has already gone sour. In any case, I can hardly be accused of trying to build up my own practice, after spending thousands of dollars in the past year to find a competent qualified competitor to share the present patient load. (Dr. Sarwar, now in solo practice of cardiovascular surgery in Anchorage.)

Warmest personal wishes and my thanks as usual.

Sincerely yours,

Arndt von Hippel, M. D.

Avh/alc

cc: Ak. Native Health Leaders

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

The Honorable Ted Stevens
United States Senate
Washington, D.C. 20510

Dear Senator Stevens:

Thank you for your letter of January 5 to Secretary Schweiker regarding the referral of cardiac patients out of Alaska by the Indian Health Service (IHS).

While the referral of patients to Dr. Sullivan in San Francisco dates back to 1971, evaluation of this program has been a continuing process. The 50 percent figure cited by Mr. Ivey in his letter of October 28 was based on information that was available up to that time. However, the analysis of information available through the end of November 1982 actually shows a greater than 50 percent savings compared to a current review of charges for similar services provided in Anchorage.

The cardiology program has not been submitted for private bids because it is provided by an IHS employee, Dr. Sullivan. When cardiac surgery is required, Dr. Sullivan is able to utilize both U.S. Government (Letterman Army Medical Center and Palo Alto Veteran's Administration Medical Center) and private (St. Mary's) hospitals, depending on which can best serve the needs of the individual patient. This flexibility of service is provided at the considerable savings noted above, and includes roundtrip airfare and surface transportation for the patient.

In order to minimize the trauma of separation of patients from their families during their evaluation and treatment in San Francisco, the IHS Alaska Area provides transportation for a family member who accompanies the patient. Housing is provided in the Letterman officers' quarters when that hospital is used, and in hotels near St. Mary's or the V.A. when those hospitals provide the surgery.

Dr. Sullivan provides regular cardiology clinic services at all Alaska Area Service Units in addition to the direct cardiology/cardiac surgery services in San Francisco. This provides a continuity of care for cardiac patients which would not be available otherwise.

We share your concerns regarding the patient and family needs surrounding cardiac care. We are also concerned that we receive the very most for our health care dollars. It is for those reasons that the cardiology program was developed with Dr. Sullivan and is continued today.

Sincerely yours,

ENBrandt

Edward N. Brandt, Jr., M.D.
Assistant Secretary for Health

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United States Senate
COMMITTEE ON APPROPRIATIONS
WASHINGTON, D.C. 20510

March 15, 1983

Arndt von Hippel, M.D.
3300 Providence Drive, Suite 2
Anchorage, Alaska 99504

Dear Arndt:

Enclosed is a copy of the reply received from the Assistant Secretary for Health in response to my most recent inquiry on your behalf.

I hope this information helps clarify this policy of the Indian Health Service.

With best wishes,

Cordially,

Ted Stevens
TED STEVENS

Enclosure

• CARDIOVASCULAR AND THORACIC SURGERY •

ARNDT von HIPPEL, M.D.

SUITE 204,
3300 PROVIDENCE AVE.
ANCHORAGE, AK 99504

OFFICE 561-1174
RESIDENCE 279-[illegible]

March 29, 1983

The Honorable Ted Stevens
United States Senate
Washington, D. C. 20510

Dear Senator Stevens:

I wish to make a final statement on the matter of IHS referrals to San Francisco, the subject of several recent letters by me.

(1) It remains bad medical practice to subject an individual who may or may not have a serious heart condition to a long trip for evaluation, particularly when there are fully qualified, experienced, dedicated cardiologists available 24-hours per day, 365 days per year right here in Alaska. In our correspondence I have documented deaths as well as at least one lawsuit related to this policy.

(2) It cannot be less expensive to send any person not requiring extensive procedures (plus a relative) to San Francisco. How do they determine which person will need such procedures or surgery without a cardiologist here in Alaska? Do they believe that Natives require evaluation only when Dr. Sullivan happens to be in Alaska? Many patients requiring a prompt cardiologist's intervention will be unable to wait for these clinics, and thus be neglected in their time of need. Obviously it is not possible to send every patient at risk plus a relative to San Francisco. As I have shown, inadequate medical care leading to deaths has resulted from these long distance arrangements.

(3) Even if the IHS could arrange free medical care and free housing for all Alaska Natives requiring cardiac catheterization and surgery in San Francisco, the cost of transportation of patient and family member would equal that of heart catheterization much more efficiently performed here in Anchorage. Equally of concern is the probability that those Natives referred to San Francisco are more likely to undergo cathetherization or other procedures simply to justify their trip.

(4) The statement that care is provided at less cost in San Francisco represents a typical bureaucratic cost shuffle. The attributable cost of in-patient medical care in a government institution is the entire facility and staff budget divided by the number of significantly ill patients they treat. Certainly by this criterion our care is far less expensive. Even if some bureaucrat can show that the entire cost has been shifted to the VA or Army from the IHS budget, it is still my tax dollar supporting a costly and inefficient system.

(5) If the VA and military and St. Mary's Hospital are so eager to take these patients and even willing to subsidize their care with non-IHS tax dollars I can only conclude that

(A) They need more patients to justify the overhead and existence of their institutions, in which case these redundant institutions should be combined or closed to save health dollars

or (B) Their training programs need more poor uninsured patients on whom to teach diagnostic and surgical techniques. Such program needs should not be allowed to control our Alaska Natives medical destiny, when better care and follow-up are available locally in Alaska.

(6) For many reasons, including proximity, our cardiology and surgical results are clearly better than theirs. I would be delighted to compare my mortality and complication rates with that in any or all of these institutions.

(7) I don't need the business as I have enough to do, but I feel that inferior or inadequate care should be publicized wherever it exists. The IHS would not be obliged to use me in any case, as there are other surgeons here.

(8) Finally, I am becoming impatient with IHS lies and obfuscations. It is apparent that the IHS remains a non-responsive, unchangeable organization that must be pressured in some other fashion if those Native patients requiring prompt cardiology consultation or heart surgery are to get a fair shake. I will so advise the Alaska Native leaders on whose behalf I have undertaken this effort.

Thank you for your several attempts at intercession. Perhaps it will take litigation to upgrade IHS services.

Sincerely,

Arndt von Hippel, M. D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control

Alaska Area Native Health Service
P.O. Box 7-741
Anchorage, Alaska 99510

September 28, 1983

REC[illegible] 1983

Patricia M. Zell
Staff Attorney
United States Senate
Select Committee on Indian Affairs
Washington, D.C. 20510

Dear Ms. Zell:

I am replying to your letter of September 22, 1983, regarding the proposed plan of attack on the current epidemic of Hepatitis B virus in Alaska. Either at the time of the hearing or shortly after a copy of the contract between the Indian Health Service and the State of Alaska, I believe, was submitted to Senator Murkowski's office. At the time of the hearing this contract outlined the plan of attack for the first year of the project. I am resubmitting to you a copy of this contract for your records. In addition, since June of 1983, further progress has been made in our program. The State of Alaska has developed a tentative screening and vaccination schedule for southwestern Alaska, a copy of which I am including. If the State of Alaska is able to accomplish this task, which I believe they will, they will be approximately three to four months ahead of schedule. Thus, if we are able to receive the funds from Congress that we have requested, we could get a good headstart on screening and vaccination for the second year of the contract. This would mean that we would be able to complete screening and vaccination in the high risk areas in about a year from the time that we started. The lower risk areas would be screened and vaccinated over the next one and half to two years following completion of the high risk areas. Accelerating our effort in the high risk areas would have a great impact on reducing the number of new cases of Hepatitis B that would occur in Alaska per year.

Two other aspects of the program are well under way, one is screening carriers of Hepatitis B virus for alpha-fetaprotein (AFP) in order to, hopefully, detect the development of primary liver cancer early. We have expanded our screening to AFP in the last three months, and as a result have detected four patients who were without symptoms, three of these had early primary liver cancers. Most recently, a ten-year-old child from Fairbanks, using this blood test, was detected to have a liver cancer which we removed and believe that there is a high chance for cure in this patient. Armed with these successes we are expanding this screening program to include all carriers of Hepatitis B virus in the State. This expansion should be completed shortly after January of 1984. Again, it is crucial that we receive adequate funds to support the laboratory personnel that we need to do the alpha-fetaprotein screening, as well as clerical support to send reminder letters to patients and providers to have these high risk patients' bloods drawn.

A third aspect of the program is the screening of all pregnant women and treatment of any children who are born from pregnant women who are carrying Hepatitis B virus with hyperimmune B globulin and Hepatitis B vaccine. We have recently expanded our screening to include Bristol Bay, Kotzebue, Ketchikan and Mt. Edgecumbe areas, as well as Yukon-Kuskokwim and Anchorage areas. In the next six months we will include Barrow, Nome, Fairbanks and Juneau, so that the entire native population will be covered by this part of the program.

In addition to the public health programs covered above, we hope to continue our clinical investigation work into Hepatitis B which would include such important projects as a study to determine how long immunity from Hepatitis B vaccine will last so that we can adequately plan booster doses of Hepatitis B vaccine; an investigation to determine the interaction of Hepatitis B vaccine with other childhood immunizations, and a search for other tumor markers which could help us,in the future to identify those Hepatitis B carriers who are at the highest risk of developing liver cancer.

We sincerely appreciate the interest and support that Senator Murkowski and the Select Committee on Indian Affairs has shown concerning the problem of Hepatitis B in Alaska. We will continue to do everything we can to slow this epidemic down as fast as possible. Please share this information with Senator Murkowski and again, thank you very much for your interest in Hepatitis B.

Sincerely,

Brian James McMahon, M.D.
Alaska Area Hepatitis B Coordinator
Alaska Area Native Health Service
Indian Health Service
Alaska Native Medical Center

Enclosures

cc: Dr. Everett Rhoades
Dr. Ward Hurlburt
Mr. Gerald Ivey
Dr. Elizabeth Tower

SCREENING SCHEDULE

		Population
August 9	Quinhagak	427 (375)
August 22-23	Nightmute	141 (150)
August 29	Igiugig Gulkana	c.50 c.50
August 30	Levelock	c.100
September 1-2	Dillingham	1,791
September 6	Ekwok Clark's Point	78 80
September 7-8	Manokotak	299
September 6-9	Scammon Bay	251
September 12-14	Crooked Creek Red Devil	c.150 c.50
September 14-16	~~Akiachuk (½ village not screened by CDC)~~	231 of 451
September 19-23	Akiachu - Akolmuit (Kasigluk & Nunapitchuk)	221 of 451 641
September 26-30	Eek Akiak Tuluksak (½ village not screened by CDC) ?Aleknagek ?Portage Creek	235 229 136 of 243 232 c.100
October 3-7	St. Mary's Mountain Village Grayling Shageluk Anvik Holy Cross	442 249 of 601 211 132 114 241
October 10-14	Sleetmute Kwigillingok Kongiganak ?New Stuyahok ?Koliganek	c.100 c.150 c.150 331 c.150
October 17-21	Tununak Toksook Bay	302 357
October 24-28	?Dillingham School ?Togiak	(1,791) 507

Screening Schedule,
Page Two

November 1-4	Kipnuk	c.500
November 7-11	Goodnews Bay	173
	Platinum	57
November 1-11	Upper Kalskag	155 of 260
	Lower Kalskag	89 of 133
	Emmonak	289 of 581
	Alakanuk	283 of 546
Remaining unscreened portions of villages probably by CDC teams	Kotlik	169 of 347
	Chevak	197 of 513
	Hooper Bay	385 of 651
	Kwethluk	248 of 467
	Pilot Station	89 of 337
	Pitka's Point	35 of 88
	Stebbins	41 of 321
	St. Michael	159 of 295
November 14-18	Aniak	351
	Chuathbaluk	124
	Atmauthluak	236
November 28-December 2	Mekoryuk	178
December 12-16	Newtok	175
January 14	Chefornak	244
January 23-27	Napakiak	286
	Napaskiak	251
	Oscarville	c.50

To be worked in: Naknek-South Naknek-King Salmon (1,200)
Bethel Kindergarten and Pre-school (500)
Alaska Peninsula Villages

Awaiting: North Slope Borough Plan and forming suggestions for Unalakleet, Galena and Fort Yukon.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE NEGOTIATED CONTRACT	CONTRACT NO. 243-83-0092	PAGE 1 OF 63 PAGES
	NEGOTIATED PURSUANT TO 41 USC 252 (c) (2)	TYPE OF CONTRACT Fixed Price
ISSUING OFFICE HRSA, Alaska Area Native Health Service Area Purchasing & Contract Section P.O. Box 7-741 Anchorage, Alaska 99510	CONTRACT FOR Hepatitis B Control and Immunization	
CONTRACTOR (Name and Address) State of Alaska Dept. of Health & Social Services Division of Public Health Pouch H06, Juneau, Alaska 99811	ACCOUNTING AND APPROPRIATION DATA 25.1S or 25.22 7530390 3599147 3-39159.25 (19)	
PLACE OF PERFORMANCE State of Alaska	CONTRACT AMOUNT $435,000	
MAIL VOUCHERS TO HRSA, Alaska Area Native Health Service Attn. Area Financial Management Branch P.O. Box 7-741 Anchorage, Alaska 99510	SPONSOR A-CHSB3-074	
	EFFECTIVE DATE 3/1/83	EXPIRATION DATE 2/29/84

CONTRACTOR REPRESENTS

1. That it ☐ is, ☐ is not, a small business concern. If he is a small business concern and is not the manufacturer of the supplies to be furnished hereunder, he also represents that all such supplies ☐ will, ☐ will not, be manufactured or produced by a small business concern in the United States, its possessions, or Puerto Rico. (A small business concern for the purpose of Government procurement is a concern, including its affiliates, which is independently owned and operated, is not dominant in the field of operation in which it is contracting and can further qualify under the criteria concerning number of employees, average annual receipts, or other criteria, as prescribed by the Small Business Administration.) (See Code of Federal Regulations, Title 13, Part 121, as amended, which contains detailed definitions and related procedures.)
2. That it is a ☐ REGULAR DEALER IN, ☐ MANUFACTURER OF, the supplies covered by this contract
3. That it is an ☐ INDIVIDUAL, ☐ STATE OR LOCAL AGENCY, ☐ PARTNERSHIP, ☐ JOINT VENTURE, ☐ NON-PROFIT, ☐ EDUCATIONAL INSTITUTION, ☐ CORPORATION organized and existing under the laws of the state of

The Contractor agrees to furnish and deliver all supplies and perform all the services set forth in the attached Special Provisions, for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the Special Provisions and the General Provisions. To the extent of any inconsistency between the Special Provisions or the General Provisions and any specifications or other provisions which are made a part of this contract, by reference or otherwise, the Special Provisions and the General Provisions shall control. To the extent of any inconsistency between the Special Provisions and the General Provisions, the Special Provisions shall control.

IN WITNESS WHEREOF, the parties hereto have executed this contract on the day and year last specified below.

NAME OF CONTRACTOR	UNITED STATES OF AMERICA
BY /S/ ROBERT SMITH SIGNATURE OF AUTHORIZED INDIVIDUAL	BY /S/ D. SEGELHORST SIGNATURE OF CONTRACTING OFFICER
TYPED NAME TITLE	TYPED NAME 3/1/83 DATE
2/25/83 DATE	

HEW-564 (7/70)

CONTRACT NO. 243-83-0092	CONTENTS OF CONTRACT	PAGE 2 OF 63 PAGES

THIS CONTRACT CONSISTS OF:

1. Cover Page HEW-554

2. Special Provisions HEW-556

ARTICLE I	SCOPE OF WORK
ARTICLE II	PAYMENT
ARTICLE III	DEFINITIONS
ARTICLE IV	AUTHORIZATIONS
ARTICLE V	QUALITY OF CARE
ARTICLE VI	PROJECT OFFICER
ARTICLE VII	RECORDS AND REPORTS
ARTICLE VIII	PERIOD OF PERFORMANCE
ARTICLE IX	DURATION OF REQUIREMENTS CONTRACTS AND HRSA THREE YEAR POLICY
ARTICLE X	WITHHOLDING OF CONTRACT PAYMENTS
ARTICLE XI	EXCUSABLE DELAYS

3.	General Provisions, HEW Form 314 (Rev. 9/76) Negotiated,	43 Page
4.	Alterations and Additional General Provisions, 9/76	4 Page
5.	Exhibit "A", Privacy Act of 1974	7 Page
6.	Principles of Medical Ethics	1 Page

ARTICLE I - SCOPE OF WORK:

A. Goal

The ultimate goal of this contract is to prevent Hepatitis B Virus (HBV) Infection among Alaska Natives in Alaska.

Upholding this goal are three subgoals, each with a three-year target:

1. to serosurvey Alaska Natives for evidence of HBV infection,
2. to vaccinate all higher risk Alaska Natives susceptible to HBV infection, and
3. at the end of this time to have established an ongoing Hepatitis B Virus Control and Immunization Program for the Alaska Native community.

B. General Conditions

1. Introduction

Hepatitis B Virus (HBV) appears to have been introduced recently into the Alaska Native Community Seriologic Studies of selected Native groups indicate that HBV infection is spreading in this highly susceptible population. Following an infection with the HBV, a significant number of individuals become asymptomatic carriers of the virus, and as long as an individual is a carrier he/she can be a source for new infections in others and is at risk of serious life threatening complications.

A vaccine efficacy trail, recently completed in Western Alaska on 1700 Alaska Eskimos, demonstrated excellent immune response in the individuals receiving vaccine. On June 25, 1982 the Immunization Practices Advisory Committee (ACIP) recommended the use of the inactivated HBV vaccine in individuals at risk for HBV infection (MMWR, Vol. 31, No. 27).

2. Population at Risk

Because of high carrier prevalence, defined as Hepatitis B surface antigen positive (HBsAg+), the ACIP has identified the Alaska Eskimos as a "special high risk population" (MMWR, Vol. 31, No. 24, P. 327). Additional data being collected by the Arctic Investigations Laboratories, Centers for Disease Control, are suggesting that other Native subpopulations in Alaska may also be high risk for Hepatitis B infections.

If all susceptible Alaska Natives at risk are to be immunized, it is estimated that about 45,000 individuals in the state would need vaccine. If only the highest risk in the high risk Native community are to be immunized, about 20,000 to 30,000 individuals would need vaccine. These estimates can be made more exact after additional serosurvey efforts are analyzed. Before a conclusive number of Native persons needing vaccine can be determined, the majority of Alaska Natives will need to be serologically tested.

3. Program Determinants

A HBV Control Program requiring vaccination of a large number of high risk individual in a susceptible population is complex. Serologic studies on large numbers of individuals in the population in question are needed before a vaccine series is administered. Arranging the logistics to accomplish the tasks and recording and retrieving the data are complicated. All program components need to be in place, adequately tested and well coordinated.

More specifically the following elements need to be recognized as important factors that will affect the management of the work in this contract.

a. Acceptance by the Native community and by individuals in the community.

b. Population availability considering seasonal movement.

c. State and Federal funding levels. Refer to attached, Hepatitis B Virus Infection: Prevention Program Proposal. Also refer to a state document, Hepatitis B Virus (HBV).

C. State of Alaska Contract Objectives

1. To identify and vaccinate Alaska Natives who are high risk for HBV infection: target about 7,500 individuals by the end of one year after contract beginning date, including.

   a. all newborns of HBsAg+ mothers, in cooperation with the Alaska Area Native Health Services (AANHS) physician staff,

   b. susceptible individuals in households of known and newly identified HBsAg+ individuals,

   c. susceptible individuals in villages or communities which have 5% or more persons who are HBsAg+, and

   d. AANHS and Native Health Corporation health care workers who are considered high risk.

2. To assume responsibility for the administration of the HBV vaccination program as it relates to AANHS beneficiaries.

   a. vaccine distribution to meet the risk priorities needs outlined in the State of Alaska-Alaska Area Native Health Service Memorandum of Understanding,

   b. community education about HBV infection and prevention,

   c. information to potential vaccine recipients about and the opportunity to refuse HBV vaccine,

   d. documentation, monitoring and evaluation of possible vaccine related complications,

e. monthly meetings with the Project Manager and Project Officer to exchange information and for progress review.

f. Insofar as the HBV Control and Immunization program relates to AANHS beneficiaries, the Project Officer will be informed and consulted on program development and implementation.

3. To determine susceptibility to and risk of acquiring HBV infection in Alaska Natives: Target about 20,000 individuals by the end of the contract year.

a. Serosurvey household contacts of known or newly identified HBsAg+ individuals,

b. serosurvey all individuals in communities of areas of suspected high prevalence of HBsAg+ individuals.

   a. Yukon-Kuskokwim Delta,
   b. Kotzebue Service Unit,
   c. Norton Sound Service Unit,
   d. Bristol Bay Service Unit, and
   e. Barrow Service Unit,

c. Provide quality laboratory services for the serosurvey needs of the HBV Prevention and Immunization Program, and

d. provide the Arctic Investigations Laboratories, Centers for Disease Control, an aliquot of serum from most Native beneficiaries who are serosurveyed and serum aliquot of all HBsAg+ individuals as outlined in the State of Alaska - Alaska Area Native Health Service memorandum of understanding.

4. To ensure acceptable computer services to meet the needs of Hepatitis B control and vaccination of the AANHS beneficiaries.

a. entry of individual serologic and immunization status data into the individual health record.

b. maintenance of a heptatitis B registry, and

c. retrieval of data that will identify high risk subpopulation groups.

d. distribute serosurvey data to AIL, CDC Director and AANHS, Project Officer.

D. U.S. Governmental Agencies Responsibilities

1. To provide HBV serologic laboratory services for the clinical and prenatal screening needs of the AANHS.

2. Identify and assign a Project Manager and Project Officer to the contract.

3. To provide the State of Alaska about 5000 vials of vaccine (approximately 7500 individual immunization services).

4. To pay the State of Alaska through a fixed price contract $435,000 for the services outlined in the work of this contract.

5. To encourage involved Service Units to assign personnel to assist the State of Alaska with the activities required to meet the terms of this contract.

E. The Contractor shall comply with the requirements of the "Privacy Act" (General Provision No. 42) as they relate to the maintenance and disposition of the system(s) of records identified in Exhibit "A" of this contract.

ARTICLE II - PAYMENT:

A. Payment shall be made in the amount of $435,000 to be disbursed in equal monthly amounts of $36,250.00. Disbursements shall be made upon the receipt of properly executed vouchers, certified and submitted in quadruplicate to the address indicated on Page 1, marked attention: Financial Management Branch.

ARTICLE III - DEFINITIONS: The following definitions will be used in this contract.

A. AANHS - Alaska Area Native Health Service, located at Box 7-741, Anchorage, Alaska 99510.

B. Area Director - The person occupying the position of Area Director, AANHS.

C. Alaska Native or Native - an Indian, Aleut, or Eskimo in Alaska who is eligible for medical services under the provisions of this contract. Generally, a Native is eligible for services under this contract if he is regarded as a Native by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction. (42 CFR 36.12 (a)(2) refers). Questions of eligiblity of a particular person will be resolved by the Contracting Officer or his designated representative.

ARTICLE IV - AUTHORIZATION:

A. No provision of this contract shall be interpreted by binding the AANHS to pay for any services or benefits provided by the contractor or any other organization or individual unless such services or benefits are authorized by the Authorizing Official.

ARTICLE V - QUALITY OF CARE:

A. Proper and adequate medical care shall be rendered in accordance with the "Principles of Medical Ethics" of the American Medical Association (attached), and shall be equal to the quality of services the contractor normally provides the general public.

SPECIAL PROVISIONS	CONTRACT NO. 243-83-0092	PAGE 7 OF 63 PAGES

ARTICLE VI - PROJECT OFFICER:

Brian McMahon, M.D., Hepatitis B Control Officer will serve as the Project Officer.

Alternate Project Officer: George Brenneman, M.D, Chief, Area Community Health Services Branch, Anchorage, Alaska.

ARTICLE VII - RECORDS AND REPORTS:

A. It is essential that adequate medical records be maintained. The Contractor agrees to keep medical records appropriate for the specialty services provided on all patients seen under this contract. The Contractor, will also insure that his input into the patient record conforms with the hospital by-laws and Joint Commission for Accreditation of Hospital requirements.

B. All medical records shall be confidential, current and accurate. The contractor agrees to abide by all State and Federal requirements regarding the physician-patient privilege.

C. The Contracting Officer, or his designated representative, shall be entitled to visit the contractor's place of business to review administrative and clerical records. Records pertaining to patient care will only be reviewed when authorized by the Area Director.

D. The contractor will notify the Project Officer of conditions that are potentially hazardous to the health of the community.

ARTICLE VIII - PERIOD OF PERFORMANCE: The performance period of this contract shall be from Date of Award for a one year period.

ARTICLE IX - DURATION OF REQUIREMENTS CONTRACTS AND HRSA THREE YEAR POLICY:

A. This contract shall continue in effect for a period of three years from the effective date of this contract unless otherwise terminated.

B. However, continuation of this contract beyond the first year is contingent on the findings of annual reviews to be conducted by the Government to determine if:

1. The services called for during the previous period have been satisfactorily delivered;
2. A valid requirement exists and appropriations are available for continuation of the services;
3. The Contractor has the capability to continue to perform such services; and
4. Prices (or fees) remain reasonable.

C. The Government does not hereby commit itself or undertake any obligation to continue this contract for the full three year period unless it is satisfied that the criteria in (B) above has been met.

ARTICLE X - WITHHOLDING OF CONTRACT PAYMENTS:

Notwithstanding any other payment provisions of this contract, failure of the contractor to submit required reports when due, or failure to perform or deliver required work, supplies, or services, will result in the withholding of payments under this contract unless such failure arises out of causes beyond the control, and without the fault of negligence of the contractor as defined by the clause entitled "Excusable Delays", "Default", "Termination", or "Termination of Default" as applicable. The Government shall promptly notify the contractor of its intention to withhold payment of any invoice or voucher submitted.

ARTICLE XI - EXCUSABLE DELAYS:

Except with respect to failures of subcontractors, the Contractor shall not be considered to have failed in performance of this contract if such failure arises out of causes beyond the control and without the fault or negligence of the Contractor.

Such causes may include, but are not restricted to, acts of God or of the public enemy, acts of the Government in either its sovereign or contractual capacity, fires, floods. epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather, but in every case the failure to perform must be beyond the control and without the fault or negligence of the Contractor. If the failure to perform is caused by the failure of a subcontractor to perform and if such failure arises out of causes beyond the control of both the Contractor and subcontractor and without the fault or negligence of either of them the Contractor shall not be deemed to have failed in performance of this contract, unless (a) the supplies or services to be furnished by the subcontractor were obtainable from other sources, (b) the Contracting Officer shall have ordered the Contractor in writing to procure such supplies or services from such other sources and (c) the Contractor shall have failed to comply reasonably with such order. Upon request of the Contractor, the Contracting Officer shall ascertain the facts and extent of such failure and, if he shall determine that any failure to perform was occasioned by any one or more of the said causes, the delivery schedule shall be revised accordingly, subject to the rights of the Government under the termination clause hereof. (As used in this clause, the terms "subcontractor" and "subcontractors" means subcontractor(s) at any tier.)

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Frank Murkowski
United States Senate
Washington, D.C. 20510

Dear Senator Murkowski:

This is in response to your recent letter regarding the Hepatitis B Control Program in Alaska.

The Department shares your concern about this problem and about the health effects of acute and chronic hepatitis. The Hepatitis B Control Program for Alaska Natives is a high priority issue for the Public Health Service, in particular, the Indian Health Service (IHS) of the Health Resources and Services Administration. Earlier this month, Dr. Everett Rhoades, Director, IHS, met with several representatives of the IHS Alaska Area Native Health Service (AANHS) to discuss the Control Program and its progress.

As you are aware, the Control Program proposal, a copy of which is enclosed, was developed as a joint effort by the Centers for Disease Control, the IHS AANHS and the Alaska State Department of Health and Social Services. We believe this Control Program is the most prudent and responsible approach to this large-scale health problem. This carefully planned, step-wise approach to screening, performing epidemiological studies, and vaccinating was developed in the best interests of the total Alaska Native population. The Control Program proposal, if carried out as planned, should result in control of the Hepatitis B epidemic in Alaska at the earliest possible date and with a minimum of unnecessary cases of hepatitis and unnecessary vaccination.

The Chief Medical Officer, AANHS, has informed me that the "3,650 new cases" figure cited to you is high and that the best estimate for expected new cases this year is in the vicinity of 1800. He also estimate that if this Control Program is implemented, the number of cases would be reduced to about 1200. The Chief Medical Officer also has assured me that the State of Alaska, while having required some time to get its program implemented, has been able to process the screening samples submitted by the IHS. Any backlog of samples that might have occurred has not affected the treatment provided to the Alaska Natives.

Thank you for advising me of your interest and concern regarding this matter.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

Enclosure

HEPATITIS B VIRUS INFECTION:
Prevention Program Proposal

I. Background

From Indian Health Service (IHS) and Centers for Disease Control (CDC) collaborative studies, it has been found that the prevalence of Hepatitis B Virus (HBV) infection in some Alaska villages is as high as 27.9%. This is over 50 times higher than the rates found in other USA populations. Blood samples from all patients entering the Bethel hospital revealed that 10% were hepatitis B surface antigen (HB_sAg) positive. (HB_sAg is a measurable serum factor that indicates active infection). The infection is not always benign and transient, for it has been found that up to 50% of children under 10 years of age in some villages are chronically infected with HBV.

Because of variation of Hepatitis B Virus (HBV) infection prevalence between villages, tabulated in Table 1, and other research data, the HBV appears to have been recently introduced into and to be spreading in the susceptible Native community. Prospective studies have shown an annual incidence in the Yukon-Kuskokwim villages of 8% with variation from village to village of 2.4 to 33.8%.

Table 1

HBV Vaccine Demonstration Project
Village Serosurvey - May, 1981

	HB_sAg + (%)(1)	Total Sero(2) positive (%)
Lower Kalskag	30 (27.5)	54 (49.5)
Stebbins	66 (25.3)	173 (66.3)
Tuluksak	13 (13.7	51 (53.7)
Kwethluk	34 (13.6	139 (55.6)
Akiachak	27 (12.9	161 (77.0)
Pilot Station	24 (8.6)	118 (42.1)
Mt. Village	40 (8.4)	148 (31.3)
St. Michael	13 (8.1)	61 (38.1)
Hooper Bay	24 (7.9)	120 (39.6)
Upper Kalskag	4 (7.1)	17 (30.4)
Emmonak	23 (5.9)	80 (20.6)
Kotlik	12 (5.1)	52 (22.1)
Pitka's Point	4 (5.0)	25 (31.3)
Chevak	8 (2.5)	45 (13.9)
Alakanuk	4 (1.2	41 (12.3)
Toksook Bay	3 (1.0)	44 (14.2)
Mekoryuk	0 (0.0)	14 (11.5)

(1). HB_sAg positive indicates infectivity.

(2). Seropositive indicates that the person has recovered or still has HBV infection.

Observations of the patterns of HBV infection have been documented.

1. Household contacts of infections persons (HB_sAg positive) have a 25% chance per year of acquiring infection.

2. Children under 10 years of age generally have a 17% chance per year of acquiring infection.

3. Adults, in contrast to children, much more often experience significant morbidity from acute HBV infection.

4.. Twenty-four percent of children less than 4 years of age will become chronic HBV carriers following HBV infection. Chronic carriers become a source of infection to susceptible contacts and are at risk of developing primary liver cancer and cirrhosis.

5.. A newborn of a mother who is HB_sAg positive has a 100% risk of becoming infected with HBV.

6. Newborns infected around the time of birth have an 80% risk of becoming chronic carriers.

7. Once an individual becomes a chronic carrier, the chances of losing the carrier status is probably not better than 2% per year.

These observations, made in Alaska and worldwide studies, show the HBV to be very infectious and to be spreading within a very susceptible population. The infection can become chronic and thus give rise to a reservoir of infectious individuals.

Allusion to the morbidity caused by acute HBV infection has been made, but the importance of HBV infection is most evident when late complications resulting from an earlier infection are examined.

1. Polyarteritis Nodosa

   Polyarteritis Nodosa (PAN) is a serious inflammatory condition of the arteries that can follow an acute HBV infection. Alaskan Eskimos have the highest incidence of PAN recorded anywhere in the world with 15 to 20 cases annually per 100,000 total population. PAN has a 30% mortality rate and those who survive require intensive treatment with toxic drugs for as long as 3 years.

2. Primary Hepatocellular Carcinoma

   Primary Hepatocellular Carcinoma (PHC) is a lethal cancer that may occur as a result of the chronic carrier state. Alaska Eskimos have the highest incidence of PHC in the USA and one half of the victims are less than 30 years of age. It is estimated that 10% of HBV chronic carriers will develop PHC. At this rate PHC may become one of the most common cancers in Alaskan Natives in 30 to 40 years time.

Although newer and hopefully effective forms of therapy are being developed for PHC, present therapeutic efforts are ineffective. In some parts of the world, methods to recognize early the presence of PHC have resulted in cures, but ultimately, the only way lives can be saved from this lethal complication is with primary prevention.

3. Chronic Active Hepatitis with Cirrhosis

Chronic Active Hepatitis with Cirrhosis (CAH) is a progressive HBV infection in the liver which may eventually impair liver function. It is estimated that 20% to 25% of chronic HBV carriers will develop CAH. This complication also involves costly, difficult and usually unsatisfactory treatment. Mortality due to CAH is significant. As more susceptible persons acquire HBV infection CAH will become more evident and require expensive health care resources.

II. Program Considerations

A. Introduction

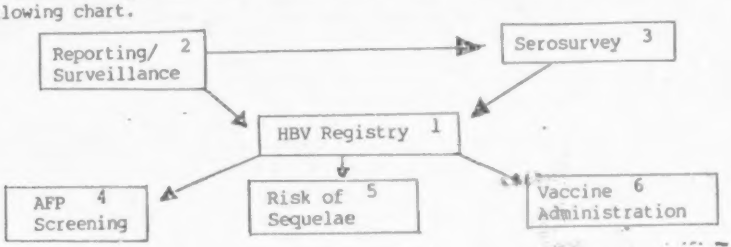
Now that a highly effective and safe vaccine (Heptovax) to prevent HBV infection is available, the Alaska Native Health Service Area Long Range Objective, "to establish a program to control the spread of HBV infection in the Alaska Area by FY 1985", can be a reality. The possibility to expand a HBV prevention program to include effective secondary prevention is also a reality because of available biochemical technology to detect subclinical PHC. Alphafetoprotein (AFP) blood levels rise sharply when PHC is present.

B. Organization

An effective primary and secondary prevention program has to contain these essential elements.

1. Registry of all HB_s individuals.
2. Reporting and Surveillance of all new cases of HBV infections and identified infectious individuals.
3. Serosurvey of at-risk subpopulation groups.
4. Alphafetoprotein (AFP) screening of the population at-risk of secondary disease.
5. Identification of secondary disease determinants through collection and analysis of registry data.
6. Vaccine administration to all high risk susceptible individuals.

The relationships of these essential elements are graphically shown in the following chart.



C. Objectives

To meet the ultimate objective, ".... to control the spread of HBV infection ...", and to satisfy the requirements of a rational primary and secondary prevention program, seven objectives have been established.

1. To vaccinate all newborns whose mothers are Hepatitis B surface antigen (HB_sAg) positive and/or who will be living in villages where the prevalence of HB_s Ag is 5% or greater.
2. To make hepatitis vaccine available to all new AANHS and Native Corporation employees who are susceptible and who are providing direct health care services by September 1985.
3. To conduct a serosurvey of the entire Alaska Native population in order of greater at-risk subpopulations by September 1985.
4. To vaccinate all at risk household contacts of potential infectious household members (HB_s Ag positive) by September 1985.
5. To vaccinate all Natives living in villages where the prevalence rate of infectious (HB_sAg positive) individuals is 5% or higher of the total village population by September 1985.
6. To provide AFP screening on a continuous basis to all HB_sAg positive individuals.
7. To determine the risk of sequelae following HBV infection by September 1985.

III. Program Costs

A. Quality of Life

Control of HBV infection in the Native community would not only reduce significant disease morbidity but prevent unnecessary death. Deficient quality of life and premature death of children and productive adults cannot be judged with cost-effective standards. The mission of the Alaska Native Health Service has to come to bear upon the problem of HBV infection; "to raise the health status of the Alaska Native to the highest possible level...." Improved quality of life is best enhanced through prevention means, and prevention is usually the most cost-effective means of health care.

B. Non-intervention

Although specific costs for individual patients' care are difficult to itemize in the IHS health care system, attempts were recently made to calculate costs incurred in the care of patients with HBV infection. Transportation costs were included and the hospital and clinic rates charged to nonbeneficiary patients were used.

Considering the present rates of infection, the annual disease frequency and cost estimates can be made and are tabulated in the following table with footnotes.

Table II

Estimated Disease Frequency and costs

Disease Entity	Expected Cases	Estimated Cost
New infections (1)	1850	$270,000
New HB_s Ag carriers (2)	222	
Chronic HB_s carriers (3)	155	
Primary Hepatocellular Carcinoma (4)	4	40,000
Chronic Active Hepatitis with Cirrhosis (5)	31	620,000
Polyarteritis Nodosa (6)	5	100,000

(1) Inpatient and outpatient costs resulting from the care of 199 uncomplicated HBV infections was $29,000. Cost estimates therefore at $29,000 divided by 199 = $146/infection.

(2) Twelve percent of new infections will become carriers.

(3) Seventy percent of carriers will become chronic carriers.

(4) The incidence of PHC per year in the Eskimo male population is 11.2/100,000, and in the Native male population is 7.6/100,000. Once a male becomes a chronic HB_sAg carrier,

his risk of acquiring PHC is increased 300 times. Because of increasing chronic carrier rates the incidence of PHC will also increase.

(5) Patients who become chronic carriers have a 20% risk per year of developing chronic active hepatitis and cirrhosis. It has been estimated that the annual cost for the care of those patients is $620,000.

(6) When PAN is a complication of HBV infection, as much as 3 years of involved inpatient and outpatient treatment are required. This is an infrequent complication; one PAN case follows every 300 to 400 HBV infections. The treatment is costly and is estimated to be around $100,000 yearly.

Based on present knowledge these numbers are impressive. When used in program development, they must be understood in the context of our present system of care.

C. Primary/Secondary Prevention

CDC in collaboration with AANHS has just finished a hepatitis vaccine trial project which involves testing 4,000 individuals and vaccinating, in three separate doses, 1,693 susceptible individuals. During the course of this and other collaborative work on hepatitis several important observations have been made regarding a preventive program.

There has been excellent Native acceptance. The Norton Sound and Yukon-Kuskokwim Health Boards have been enthusiastic. Village persons participating in the vaccination trial have a 98% follow-up record. This reflects a health problem. The vaccine trial has proven that a prevention program for HBV control is logistically possible. Side effects from the vaccine have been limited to local injection site reactions that are mild and that occur less than 5% of the time.

Including market vaccine costs, supplies, laboratory expenses, personnel, travel and perdiem it would have cost CDC $114 per adult and $69 per child to identify the susceptible and administer the vaccine. Although not directly applicable, these costs provide a reference when projections are made for a more comprehensive preventive program.

It is anticipated that the objectives can be accomplished within three (3) years of by the end of FY 1985. After these three years of intense program action the program would lead into a maintenance phase that is not expected to require additional cost or personnel above the present levels of funding and personnel.

D. Three Year Proposed Budget - $3,088,200 (Table III)

1. Personnel ($899,450)

It is anticipated that the following "core" personnel will be needed for the three year duration of the project. Additional personnel time (clinical, statistical, administrative) will be provided at no additional cost to the project. Cost includes base, COLA and fringe benefits. Calculations also include projected increases based on cost of living increases and/or merit promotions.

a. 1 Project Officer $55,000 year one
57,500 year two
60,000 year three
$172,500 project duration

This person will be responsible on a day to day basis for project activities. Candidates will be an M.D. with epidemiology background. Pay based on a full-time Commissioned Officer (CO-4).

b. 1 Project Supervisor $18,000 year one
$19,000 year two
$20,000 year three
$57,000 project duration

This person will have ultimate responsibility for the project. This person will modify procedures, guarantee data reliability, interpret immunogenetic response rates, and be the principal liaison between IHS and other agencies. Pay based on 30% time of a medical officer's time.

c. 4 Nurse Epidemiologists $26,850 x 4 = $107,400 year one
$28,190 x 4 = $112,760 year two
$29,600 x 4 = $118,400 year three
$338,560 project duration

These people will be responsible for drawing serologies and administering vaccine to 19,000 Alaskan Natives in 150 villages. Calculations were made for "full-time equivalence" at a GS-9 level.

d. 1 Computer Programmer $32,460 year one
$34,890 year two
$37,510 year three
$104,860 project duration

Data provided by clinical, laboratory or statistical personnel will be given to this person for coding, programming, retrieval and display for interpretation. This person will also update the HBV registry including sequelae, vaccine reaction and vaccine-induced serologic response. Calculation based on full-time GS-11 salary.

e. 2 Medical Technicians $26,850 x 2 = $53,700 year one
$28,190 x 2 = $56,380 year two
$29,600 x 2 = $59,280 year three
$169,280 project duration

These people will be responsible for testing for appropriate serologic markers on all initial and serial specimens drawn during the project including testing for AFP. Based on full-time GS-9 salary.

f. 1 Clerk- typist $17,725 year one
$19,050 year two
$20,475 year three
$57,250 project duration

This person will be responsible for normal clerical functions created during this project. Pay calculated on a GS-5 full-time basis.

Resume of Personnel Needs

Project Officer	$55,000	$57,500	$60,000	$172,500
Project Supervisor	$18,000	$19,000	$20,000	$ 57,000
RN Epidemiologists	107,400	112,760	118,400	$338,560
Computer Prg	$32,460	$34,890	$37,510	$104,860
Med. Techs $53,700	$56,380	$59,200	$169,280	
Clk. Typist	$17,725	$19,050	$20,475	$57,250
STAFF 284,285	299,580	315,585	$899,450	

2. Travel ($735000)

$294,000 year one
$147,000 year two
$294,000 year three

Calculations are based on the following:

number of staff on each trip	2
average cost of round trip ticket	800 (dollars)
number of days per visit	2
number of villages in project	150
per diem per night	90 (dollars)
number of visits to each village	2.5
number of years of project	3

Therefore, if 2 staff members visit each of 150 villages between two and three times during the three years (depending on need) and spend an average of 2 days during each visit using standard perdiem and airfare rates, the calculation for total village visits is:

2 (staff) x 150 (villages) x 2.5 (visits) = 750 village visits

Cost calculations are therefore:

(800 (dollar airfare) + 180 (dollars per diem)) x 750 (village visits = $735,00

3. Supplies ($516,750)

$172,250 year one
$172,250 year two
$172,250 year three

Two types of supplies will be needed; field and laboratory.

a. Field ($144,000)
$48,000 year one
$48,000 year two
$48,000 year three

For the 3 years, it is anticipated that 60,000 patients will be bled during screening, 15,000 of which will also be tested Hb_sAg and 12,000 (4,000 per year) will also be tested for AFP. Each time we take blood, the serologic supplies would cost $1.00 per patient. Therefore, the calculation is (60,000 + 15,000 + 12,000) x 1 (dollar) = $87,000 for blood draw supplies.

Vaccination supplies are calculated on the basis of $1.00 per injection for 19,000 vaccine recipients ($19,000) for a series of 3 vaccinations ($57,000).

Therefore:

blood draw supplies	$29,000 year one
blood draw supplies	$29,000 year two
blood draw supplies	$29,000 year three
vaccine adm. supplies	$19,000 year one
vaccine adm. supplies	$19,000 year two
vaccine adm. supplies	$19,000 year three
FIELD SUPPLIES	$144,000 project duration

b. Laboratory ($372,750)

$124,250 year one
$124,250 year two
$124,250 year three

(1) Three calculations are factored:

test kits for HBV markers	$93,750	year one
	$93,750	year two
	$93,750	year three
	281,250	total
test kits for AFP	$16,000	year one
	$16,000	year two
	$16,000	year three
	$48,000	total
normal lab supplies	$14,500	year one
	$14,500	year two
	$14,500-	year three
	$43,500	total

(2) HBV markers ($281,250)

a) kits of 100 (for core) = $300
b) Of the 100, 80 are for tests and 20 are for controls
c) Therefore, $300 is needed to test 80 patients ($3.75 per patient)
d) testing for Hb_s Ag is a comparable cost
e) 60,000 people will be screened for core
f) 25% of them (15,000) will be tested for Hb_s Ag
g) Therefore, 75,000 tests at $3.75 per test necessitates $281,250 over a 3 year period ($93,750 per year).

(3) AFP testing ($48,000)

a) kit of 100 = $240
b) Of the 100, 60 are for tests, and 40 for controls
c) Therefore, $240 is needed to test 60 patients ($4.00 per patient)
d) 12,000 AFP tests (4,000 per year) will be performed
e) Therefore the calculation is 12,000 (tests) x ($) 4 = $48,000 for project, or $16,000 per year.

(4) Normal lab supplies ($43,500)
Calculation is based on 50¢ per patient test to cover pipettes, tips etc. Therefore:
60,000 (core) + 15,000 (Hb_sAg) + 12,000 (AFP) x 50 (¢) = $43,500 over a three year period or $14,500 per year

Resume of Supply Needs

	Year One	Year Two	Year Three	TOTAL
Field	$48,000	$48,000	$48,000	$144,000
Lab	$124,250	$124,250	$124,250	$372,750
TOTAL	$172,750	$172,750	$172,750	$516,750

(4) Equipment ($14,500)

One-time expenditure will have to made for the following items:

(6) Freezers @ $2,000 $12,000
Calculation based on the fact that 60,000 patients will have 1-3 blood specimens drawn during the course of the project. Therefore, we will have 90,000 specimens. Each serum bank freezer holds 15,000 one dram vials. Therefore 6 freezers will be needed.

(1) Data General terminal $2,500
Needed for data entry and retrieval. Mainframe and software will be provided at no cost to the project.

(5) Vaccine ($922,500)

1. Vaccine is on hand for the first year

2. Year 2 = 5,000 patients
4,000 adult doses at $90 per patient = $360,000
1,000 child doses at $45 per patient = $45,000
$405,000 year 2 vaccine

3. Year 3 - 7,000 patients
4,500 adult doses at $90 per patient = $405,000
2,500 child doses at $45 per patient = $112,500
$517,500 year 3 vaccine

Table III

Hepatitis B Detection, Surveillance and Control Program in Alaska Natives

Three Year Proposed Budget

$3,088,200

ITEM	YEAR ONE	YEAR TWO	YEAR THREE	TOTAL
Personnel Services	$284,285	$299,580	$315,585	$899,450
Travel	$294,000	$147,000	$294,000	$735,000
Supplies	$172,250	$172,250	$172,250	$516,750
Equipment	14,500	-0-	-0-	$14,500
Vaccine	-0-	$405,000	$517,500	$922,500
TOTAL	$765,035	$1,023,830	$1,199,335	$3,088,200